| 427-1576 | . Paragraph of The Medical Principles | ANU HUMAN SERVICES | | 14:05:34 | PRINTED: 04/26/201 |
|--------------------------|--|---|----------------------------|---|---|
| | RS FOR MEDICARE | & MEDICAID SERVICES | · | | OMB NO. 0938-039 |
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIF A. BUILDINI | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| à | | 10L014 | B. WING_ | | C 04/08/2016 |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| SANDY F | PINES | | | 11301 SE TEQUESTA TERRAGE TEQUESTA, FL 33468 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDERS PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | DBE COMPLETION |
| N 000 | Initial Comments | | N 00 | , , | |
| N 100 | 2016003021 was a concluded on Resider Liniuran and Adole The allegations well the facility is not in 483.354, Subpart G. Residential Treatm Adolescents. The Condition level out of compilance, And Seventeen standar identified to be out 10145, N0161, N0161 | at Sandy Pines titlel Treatment Facility for scents. e substantiated. compliance with 42 CFR Part, Requirements for and treatment Facilities for Children and deficiency was identified to be 42 CFR Part 483.354 Use Of (N0100). It level deficiencies were of compliance, N0125, N0140, 152, N0153, N0164, N0155, N0160, N0222. Let of the systematic practices by Inability to ensure the health care to their residents. AND on of Participation for the Use in of Participation for the Use in of Participation for the Use in the providing Services for Individuals | N 100 | 149, N152, N 153, N 154, N 155, N 161 174, N 178, N 188, N 189, N 196, N 1 222 | gulations, mend the contest ons, and CEO and sped and fress any |
| | Based on observation review, it was deter comply with the reg and to: Assure that the political region is a second to the control of the con | s not met as evidenced by: ion, interview and record mined the facility failed to ulations related to cles and procedures were was authorized to order a | | MAY 06 201 BY: | 6 |
| ABORATOR | DIRECTOR'S OR PROVID | ER/SUPPLIER REPRESENTATIVE'S SIGN | VATURE | TITLE | (XB) DATE |
| | 11m / | _ ~ | | (EO | 5/8/10 |

Say deficiency statement anding with an estartist, (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that disparts provide sufficient protection to the patients. (See instructions.) Except for nursing homes. The findings stated above are disclosable 80 days and the findings stated above are disclosable 80 days and on a transport of the provided of the provided of the provided of the findings stated above are disclosable 14 days if "Maighthe date bees documents are made available to the facility. If defidencies are made available to the facility. If defidencies are made available to the facility. If defidencies are made available to the facility.

14:05:58

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/26/2016 FORM APPROVED OMB NO. 0938-0391

31.1

| ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CL/A IDENTIFICATION NUMBER: | (X2) MULT | IPLE CONSTRUCTION | | E SURVEY |
|--|---|---------------------|---|------------------------------|---|
| | | | | | С |
| | 10L014 | B. WING _ | | | 08/2016 |
| AME OF PROVIDER OR SUPPLIER ANDY PINES | | | STREET ADDRESS, CITY, STATE, ZIP- 11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469 | CODE | |
| PREFIX (EACH DEFICIENC | ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | COMPLETION DATE |
| qualified person or (Refer to Assure that a documented (Refer to Assure that the rere assessment was c Assure that the condition of the condit | (Refer to N0125); or were in place for efer to N0140); sessment was performed by a sesment was performed by a hour after the or N0145); and a were or to N0145); and a were or to N0140); sult of a Registered Nurse locumented (Refer to N0152); lons were documented (Refer to N0152); lons and outcomes were or to N0161); lons and outcomes were or to N0161); sidents was consulted for to N0161); sidents were evaluated after the (Refer to N0174); at interventions debriefings at interventions debriefings at fidebriefing was conducted (Refer to N0174); at interventions debriefing the received treatment for (Refer to N0178); nor received treatment for me (Refer to N0196); wolved in that and supervisory staff met, es (Refer to N0202) and erforming the and | N 1(| | | THE REPORT OF THE PROPERTY OF |

14:06:15 ..-.-

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| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | ON | | APPROVED 0938-0391 |
|--------------------------|--|--|--------------------|----|---|--|----------------------------|
| | OF DEFICIENCIES IF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | (X3) DATE COM | SURVEY PLETED |
| | | 10L014 | B. WING | _ | | 04/0 | 08/2016 |
| NAME OF F | PROVIDER OR SUPPLIER | | | 51 | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| SANDY F | PINES | | | | 1301 SE TEQUESTA TERRACE EQUESTA, FL. 33469 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | 38 | (X5) COMPLETION DATE |
| N 100 | The effective resulted in the facility provision of quality | oct of the systematic practices ty's inability to ensure the health care to their residents. | N 1 | | Corrective Actions: | | |
| N 125 | 483.356 (a) PROTE and residents. | ECTION OF RESIDENTS policy for the protection of | N 1 | 25 | The Director Nursing (DON) and facility Manager () reviewed and revised the to policy related to the use and documentate and " and | facility ion of | , 2016 |
| | Based on record re failed to have polici of and who was able to au and | | | | to ensure that are required element holusted and clearly stated for interpretation. Key elements of the include: - Clarification on the definite and . - Who may authorize the use of and/or | staff policy on of | |
| | procedures tilled, " the most recent rev the most recent rev the policies and pro use of by an RN (Register Doctor) based on h the resident. The R emergency safety s procedures docume psychlatrist, if on si telephone order shi the psychlatrist, or or | of the facility's policies and and "with lew of revealed that codures documented, "The must be authorized ed Nurse) and/or MD (Medical Sisher clinical assessment of N may authorize the use of for up to one hour in an illustion []". The policies and ented the treatment team te, to assess the resident and orders, "If the treatment team vallable on site, a verbal all be obtained by the RN from zovering psychiatrist, within 30 on of the emergency | | | Requirement to obtain a physical property of the conduct document a face to face assessment he resident no later than one after the Initiation of the ana/or | and/or and nent of hour t each n the safety d the ttcome names | |

in a telephone interview conducted on 3:03 PM with the facility's Risk Manager, the

treatment team physician for the

document that consultation including

14:06:34

04/08/2016

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING __ С

10L014

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

| SANDY PINES | | | 11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469 | | |
|--------------------------|--|--------------------|---|--|--|
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFI TAG | X PROVIDERS PLAN OF CORRECTION (25) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | |
| | Continued From page 2 The effect of the systematic practices resulted in the facility's nability to ensure the provision of quality health care to their residents. | N 1 | DEFICIENCY) N 125 Continued - Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is | | |
| | Review on of the facility's policies and procedures titled, "and "with the most recent review of prevealed that the policies and procedures documented, "The use of or but be authorized by an RN (Registered Nurse) and/or MD (Medical Doctor) based on his/her clinical assessment of the resident. The RN may authorize the use of or for up to one hour in an emergency safety situation []. The policies and procedures documented the treatment team psychiatrist, if on site, to assess the resident and write the necessary orders, "If the treatment team psychiatrist is not available on site, a verbal telephone order shall be obtained by the RN from the psychiatrist, or covering psychiatrist, within 30 minutes after initiation of the emergency intervention." | | strategies to be used by use start, de resident, or others that could prevent the future use of / | | |

14:06:59

FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING

10L014

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED С

04/08/2016

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

| SANDY PINES | | | 11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469 | | |
|--------------------------|--|---------------------|--|---------------------------|--|
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) IMPLETION DATE | |
| N 100 | Continued From page 2 | N 10 | 00 | | |
| | The effect of the systematic practices resulted in the facility's inability to ensure the provision of quality health care to their residents. | | N 125 Continued | | |
| N 125 | 483.356 (a) PROTECTION OF RESIDENTS and policy for the protection of residents. | N 12 | Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of | | |
| | This STANDARD is not met as evidenced by: Based on record review and interview, the facility falled to have policies and procedures for the use of and that clearly defined | | The DON and and revised all medical records forms related to the documentation of the use of / to ensure that all required elements could be documented correctly and thoroughly. | , 2016 | |
| | who was able to authorize the use of and | | The DON, i, and designees, along with Corporate Divisional Clinical Directors, provided | , 2016 | |
| | The findings included: Review on of the facility's policies and procedures titled, "and "with the most recent review of revealed that the policies and procedures documented, "The use of or must be authorized by an RN (Registered Nurse) and/or MD (Medical Doctor) based on his/her clinical assessment of the resident. The RN may authorize the use of or for up to one hour in an | | retraining to all nurses, direct care staff, attending psychiatrists, and senior leadership on: Definition of and appropriate justification for use of and/or during for an emergency safety situation Revisions/clarifications to the Policy including: Who may authorize the use of and/or Requirement to obtain a physician's order for any use of | · | |
| | emergency safety situation []". The policies and procedures documented the treatment team psychiatrist, if on site, to assess the resident and write the necessary orders, "If the treatment team psychiatrist is not available on site, a verbal telephone order shall be obtained by the RN from the psychiatrist, or covering psychiatrist, within 30 minutes after initiation of the emergency intervention." In a telephone interview conducted on at 3:03 PM with the facility's Risk Manager, the | | physician's order for any use of analysis of Requirement to conduct and document a face to face assessment of the resident no later than one hour after the initiation of the and/or Requirement to fully document each use of and/or | | |

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION X3) DATE SUBVEY IDENTIFICATION NUMBER: A. BUILDING С 10L014 B WING 04/08/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE SANDY PINES TEQUESTA, FL 33469 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX N 100 N 125 Continued N 100 | Continued From page 2 effect of the systematic practices Requirement to document in the resulted in the facility's inability to ensure the medical record, the emergency provision of quality health care to their residents. safety situation that N 125 483.356 (a) PROTECTION OF RESIDENTS N 125 required/justified the use of and/or interventions used, and the policy for the protection of outcome of the intervention residents · Requirement to document the names of all staff involved in the and/or This STANDARD is not met as evidenced by: . Need to consult with the Based on record review and Interview, the facility treatment team for the and falled to have policies and procedures for the use resident's and that clearly defined physician for the nf and to document that who was able to authorize the use of consultation including the and ' date/time of the consult. Requirement for an MD or nurse The findings included: to evaluate the well-being of the resident immediately after the Review on of the facility's policies and the most recent review of resident is removed from " with , revealed that and/or and to document that evaluation the policies and procedures documented, "The Need to notify the resident's legal must be authorized use of . or guardian that the resident had a by an RN (Registered Nurse) and/or MD (Medical) and/or Doctor) based on his/her clinical assessment of document that notification the resident. The RN may authorize the use of Requirement to conduct and for up to one hour in an OF document a face to face emergency safety situation [...]". The policies and discussion with all staff and the procedures documented the treatment team resident involved in an emergency psychiatrist, if on site, to assess the resident and intervention. The discussion must write the necessary orders, "If the treatment team include the circumstances psychiatrist is not available on site, a verbal resulting in the use of telephone order shall be obtained by the RN from and strategles to and/or the psychiatrist, or covering psychiatrist, within 30 be used by the staff, the resident, minutes after initiation of the emergency or others that could prevent the intervention." future use of at In a telephone interview conducted on 3:03 PM with the facility's Risk Manager, the

04/08/2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

B. WING

10L014

PRINTED: 04/26/2016 FORM APPROVED OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING ___ С

NAME OF PROVIDER OR SUPPLIER

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

SANDY PINES

STREET ADDRESS, CITY, STATE, ZIP CODE

11301 SE TEQUESTA TERRACE

| TEQUESTA, FL 33469 | | | |
|---|---------------------------|--|--|
| IN SHOULD BE COMP | (X5) IMPLETION DATE | | |
| | | | |
| to complete and debriefing session ars after use of or seclusion with | | | |
| ty and/or and/or appropriate administrative the circumstances | | | |
| and 'strategles' by the staff, the others that could ther use of i, if an injury is resident during the | | | |
| and/or oriefing a plan to | | | |
| r injury is to be in documented in ord. | | | |
| to obtain and edical treatment ny injury sustained during the use of | | | |
| ulrements related | | | |
| compliance to the | | | |
| ilrements. | | | |
| com | pliance to the | | |

561-427-1576 14:08:04 PRINTED: U4/20/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING С R WING 101.014 04/08/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE SANDY PINES TEQUESTA, FL 33469 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION COM (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE UPLETION DATE TAC DEFICIENCY N 100 | Continued From page 2 N 100 The effect of the systematic practices N 125 Continued resulted in the facility's inability to ensure the provision of quality health care to their residents. N 125 483.356 (a) PROTECTION OF RESIDENTS N 125 Competency was assessed via post-tests maintained in Individual employee's HR file. Each policy for the protection of employee taking the training was also required residents to sign an attestation of his/her understanding of the expectations for compliance with established policy and documentation requirements. Nurses were additionally This STANDARD is not met as evidenced by: required to complete a correctly completed set Based on record review and interview, the facility of documents to verify understanding of the failed to have policies and procedures for the use documentation requirements. Any employee of and that clearly defined , 2016 will failing to complete training by who was able to authorize the use of be required to complete the training before and being allowed to return to work. The findings included: of the facility's policies and Review on , 2016 100% The DON/designees and/or the procedures titled, " and " with of all documents related to the use of and ongoing , revealed that the most recent review of on a daily basis to ensure the policies and procedures documented, "The compliance with documentation standards and must be authorized or policy expectations. Aggregated results of the by an RN (Registered Nurse) and/or MD (Medical) monitoring is reported monthly by the Director Doctor) based on his/her clinical assessment of of Nursing to the facility PI Committee and the resident. The RN may authorize the use of quarterly to the Governing Body. Any nonor for up to one hour in an compliance is addressed through retraining

FORM CMS-2567(02-69) Previous Versions Obsolete

intervention."

emergency safety situation [...]". The policies and

procedures documented the treatment team psychiatrist, if on site, to assess the resident and write the necessary orders, "If the treatment team psychlatrist is not available on site, a verbal telephone order shall be obtained by the RN from the psychlatrist, or covering psychiatrist, within 30 minutes after initiation of the emergency

In a telephone interview conducted on 3:03 PM with the facility's Risk Manager, the

Event ID: TIBR11

Facility ID: RC57000060P

and/or disciplinary action as appropriate.

If continuation sheet Page 3 of 4B

14:08:25

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/26/2016

| | | AND HUMAN SERVICES | | | FORM APPROVE |
|--------------------------|---|---|-----------------------------|--|---|
| | | & MEDICAID SERVICES | | | IB NO. 0938-039 |
| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING | · · · · · · · · · · · · · · · · · · · | X3) DATE SURVEY COMPLETED |
| | | 10L014 | B. WING | | C 04/08/2016 |
| NAME OF F | ROVIDER OR SUPPLIER | | s | TREET ADDRESS, CITY, STATE, ZIP CODE | |
| SANDY F | PINES | | | 1301 SE TEQUESTA TERRACE TEQUESTA, FL 33469 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD IS CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | BE COMPLETION |
| N 100 | | ect of the systematic practices | N 100 | N 125 Continued | |
| N 125 | provision of quality | ty's inability to ensure the health care to their residents. ECTION OF RESIDENTS policy for the protection of | N 125 | For a period of four months, the DON a conducting daily random audi surveillance camera of each residential area with each area viewed at time periods each shift. Any incides | ts via I unit's least 2 |
| | Based on record re | | | observed or is company of commented seclusion/ to ensu all episodes are correctly documented seclusts of the monitoring is remonthly by the Director of Nursing to the PI Committee and quarterly to the Go Body. Any non-compliance is addressed tretrolling and/or disciplinary acity appropriate. When compliance is maintail | re that nented. eported eported verning through on as |
| | Review on procedures titled, " | of the facility's policies and | | four months, the monitored will be decre a sample of each shift weekly. Responsible: | |
| | use of or by an RN (Register Doctor) based on h | riew of revealed that recedures documented, "The must be authorized ed Nurse) and/or MD (Medical is/her clinical assessment of M may authorize the use of for up to one hour in an | | Director of Nursing | |
| | emergency safety s procedures docume psychiatrist, if on si write the necessary sychiatrist is not a telephone order sh- the psychiatrist, or | tior up to one nour in all situation []". The policies and ented the treatment team te, to assess the resident and orders, "If the treatment team valiable on site, a verbal ail be obtained by the RN from covering psychiatrist, within 30 ion of the emergency | | • | |
| | In a telephone inter | view conducted on at cility's Risk Manager, the | | | |

14:08:45

PRINTED: 04/26/2016 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X3) DATE SURVEY AND PLAN OF CORRECTION A. BUILDING B. WING 10L014 04/08/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE SANDY PINES TEQUESTA, FL 33469 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX TAG (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) N 125 Continued From page 3 N 125 facility's Risk Manager explained that the policy was intended to clarify that other staff were not allowed to use or seclusions without a nurse's involvement. N 140 483,358(a) ORDERS FOR USE OF N 140 Corrective Actions: May 3, 2016 OR The Director Nursing (DON) and facility Risk Orders for Manager () reviewed and revised the facility or must be by a physician, or other licensed practitioner permitted policy related to the use and documentation of by the State and the facility to order and : and . 01 to ensure that are required elements are and trained in the use of emergency included and clearly stated for staff safety interventions. Federal regulations at 42 CFR 441.151 require that inpatient are Interpretation. Key elements of the policy include: Clarification on the definition of provided under the direction of a physician. Who may authorize the use of This STANDARD is not met as evidenced by: and/or. Based on record review, observation and Requirement to obtain a physician's interview, the facility failed to obtain a physician's order for any use of for 2 of 17 sampled order for the use of residents reviewed for seclusions and - Requirement to conduct (Resident #16 and #17). document a face to face assessment of the resident no later than one hour The findings included: after the initiation of the and/nr 1. Review on of the facility's own policies - Requirement to fully document each with the most recent review of that the pollular use of and/or ... revealed Requirement to document in the that the policies and procedures documented, medical record, the emergency safety

authorize the use of

"The use of

or

authorized by an RN (Registered Nurse) and/or

to one hour in an emergency safety situation [...]". The policies and procedures documented the

treatment team psychiatrist, if on site, to assess

Qr

MD (Medical Doctor) based on his/her clinical assessment of the resident. The RN may

for up

must be

. the

situation that required/justified the

and/or

Interventions used, and the outcome

of all staff involved in the

- Requirement to document the names

use of

and/or

Facility ID: RC57000060P

of the Intervention

14:09:06

04/08/2016

PRINTED: 04/26/2016 FORM APPROVEC OMB NO. 0938-0391 561-427-1576 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION A. BUILDING_ C

NAME OF PROVIDER OR SUPPLIER

10L014 B. WING

STREET ADDRESS, CITY, STATE, ZIP CODE

11301 SE TEQUESTA TERRACE SANDY PINES

| SANDI PINES | | | TEQUESTA, FL 33469 | | | |
|--------------------------|--|---------------------|---|--------------------|--|--|
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOPLOP BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | COMPLETION DATE | | |
| N 140 | Continued From page 4 | N 140 | N 140 Continued | | | |
| | the treatment team psychlatrist is not available on | | Need to consult with the resident's | 1 | | |
| | site, a verbal telephone order shall be obtained by | | treatment team physician for the | 1 | | |
| | the RN from the psychiatrist, or covering | | and and to | | | |
| | psychlatrist, within 30 minutes after initiation of | | document that consultation including | 1 | | |
| | the emergency intervention." | | the date/time of the consult, | 1 | | |
| | Observations conducted on at | | - Requirement for an MD or nurse to | | | |
| | approximately 9:25 AM, with the facility's Nurse | | evaluate the well-being of the resident | , | | |
| | Manager revealed an area that contained two | | Immediately after the resident is | | | |
| | , with doors in place; the doors | | removed from and/or | 1 . | | |
| | opened out to a small common area that also | | and to document that | 3 | | |
| | contained a the area was separated | | evaluation | 1 | | |
| | from a hallway that led to common areas by a set | | - Need to notify the resident's legal | | | |
| | of double doors. The Nurse Manager reported, | | guardian that the resident had a and/or and | | | |
| | during an interview, on at approximately | | document that notification | | | |
| | 9:25 AM that the facility had taken off the doors to | | - Regularement to conduct and | î | | |
| | the to avoid , but | | document a face to face discussion | 1 | | |
| | re-added them after a revision of their policies. | | with all staff and the resident involved | | | |
| | Review on of the facility's own video | | in an emergency intervention. The | | | |
| | recording revealed Residents #16 and #17 on | | discussion must include the | | | |
| | at approximately 5:00 PM, locked away | | circumstances resulting in the use of | | | |
| | from other residents, in an area that they did not | | and/or and | 1 | | |
| | frequent as part of their daily routines; The | | strategles to be used by the staff, the | | | |
| | residents were observed in the area that | | resident, or others that could prevent | | | |
| | contained the two small , without doors at | | the future use of / . | | | |
| | that time, leading into a common area that had a | | * · · · · · · · · · · · · · · · · · · · | 1 | | |
| | set of locked double doors. The area was void of | | i i | | | |
| | any furniture, except for a plastic chair. There | ~ | • • | į | | |
| | was a staff member present in the area. The | | 1 | į | | |
| | residents were observed kicking the double | | ! | 1 | | |
| | doors; the doors did not open when kicked; they | | | | | |
| | were observed pacing back and forth in the area | | : | , | | |
| | and this lasted at least 5 minutes. | | : | 1 | | |
| | Review of Resident #16's record, on | | | | | |
| | revealed that the resident was admitted to the | | 4 | 1 | | |
| | facility on . The record revealed evidence | | * | | | |
| | of documentation that the facility sent the resident | | | 1 | | |
| | to a receiving facility on | | | t | | |
| | accompanied by Law Enforcement officers after | | 4 | 1 | | |
| | the resident disrupted the unit, instigated peers | | | <u> </u> | | |

(X4) ID

TAG

561-427-1576

CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION

101 014

A. BUILDING

B. WING

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PRINTED. FORM APPROVED OMB NO. 0938-039 (X3) DATE SURVEY

C 04/08/2016

, 2016

, 2016

NAME OF PROVIDER OR SUPPLIER

SANDY PINES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE

TEQUESTA, FL 33469 PROVIDER'S PLAN OF CORRECTION (X5) MPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY

N 140 Continued From page 4

the treatment team psychlatrist is not available on site, a verbal telephone order shall be obtained by the RN from the psychiatrist, or covering psychlatrist, within 30 minutes after initiation of the emergency intervention." Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

: the area was separated contained a from a hallway that led to common areas by a set of double doors. The Nurse Manager reported. during an interview, on at approximately 9:25 AM that the facility had taken off the doors to the to avoid seclusions, but re-added them after a revision of their policies. Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not

frequent as part of their daily routines: The residents were observed in the area that , without doors at contained the two small that time, leading into a common area that had a set of locked double doors. The area was vold of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked; they were observed pacing back and forth in the area

revealed that the resident was admitted to the . The record revealed evidence facility on of documentation that the facility sent the resident receiving facility on to a accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers

and this lasted at least 5 minutes.

Review of Resident #16's record, on

N 140 N 140 Continued

document a debriefing session within 24 hours after use of and/or with the staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or strategies to be used by the staff, the resident, or others that could prevent further use of /seclusion, If an injury is sustained by a resident during the use of and/or

Requirement to complete and

further injury is to be developed and documented in the medical record. Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of

during the debriefing a plan to prevent

The DON and ! and revised all medical records forms related to the documentation of the use of to ensure that all required elements could be

documented correctly and thoroughly. , and designees, along with The DON Corporate Divisional Clinical Directors, provided retraining to all nurses, direct care staff,

attending psychiatrists, and senior leadership on: of and appropriate Definition justification for use of and/or during for an emergency safety situation

Revisions/clarifications to Restraint/Seclusion Policy Including:

FORM CMS-2667(02-99) Previous Versions Obsolute

Event ID: TI6R11

Facility ID: RC57000980P If continuation sheet Page 5 of 48

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| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | RINTED: 04/26/20 FORM APPROV MB NO. 0938-03 |
|--------------------------|----------------------------------|--|----------------------------|---|---|
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIP A. BUILDING | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | 10L014 | B. WING | | C 04/08/2016 |
| NAME OF I | PROVIDER OR SUPPLIER | | 1 | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| SANDY F | PINES | | | 11301 SE TEQUESTA TERRACE TEQUESTA, FL. 33469 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | DE COMPLETE |
| N 140 | Continued From pa | ge 4 | N 140 | N 140 Continued | |

the treatment team psychiatrist is not available on site, a verbal telephone order shall be obtained by the RN from the psychiatrist, or covering psychiatrist, within 30 minutes after initiation of the emergency intervention." Observations conducted on approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to to avoid seclusions, but the re-added them after a revision of their policies. Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not

frequent as part of their daily routines; The residents were observed in the area that , without doors at contained the two small that time, leading into a common area that had a set of looked double doors. The area was vold of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked; they were observed pacing back and forth in the area and this lasted at least 5 minutes. Review of Resident #16's record, on revealed that the resident was admitted to the . The record revealed evidence facility on of documentation that the facility sent the resident receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers

. Who may authorize the use of and/or

Requirement to obtain physician's order for any use of and/or Requirement to conduct and

document a face to face assessment of the resident no later than one hour after the and/or initiation of the Requirement to fully document

each use of · Requirement to document in the medical record, the emergency situation safety required/justified the use of and/or , the interventions used, and the outcome of the Intervention Requirement to document the

names of all staff involved in the and/nr Need to consult with the treatment team resident's physician for the and to document that consultation including the date/time of the consult.

Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and to document and/or that evaluation Need to notify the resident's legal guardian that the resident had a

and/or

| 427-1576 CENTERS FOR MEDICAR | | | | RINIED: FORM APPROVE MB NO. 0938-039 |
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| TATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDI | IPLE CONSTRUCTION NG | (X3) DATE SURVEY COMPLETED |
| | 10L014 | B. WING | | 04/08/2016 |
| NAME OF PROVIDER OR SUPPLIER | | 1 | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| SANDY PINES | | | 11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469 | |
| PREFIX (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE COMPLÉTION |

N 140 : Continued From page 4 the treatment team psychiatrist is not available on site, a verbal telephone order shall be obtained by the RN from the psychiatrist, or covering psychiatrist, within 30 minutes after initiation of the emergency intervention." Observations conducted on

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of documentation that the facility sent the resident receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers

. The record revealed evidence

revealed that the resident was admitted to the

N 140 Continued N 140

> Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must include the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent the future use of restraint/seclusion.

Requirement to complete and document a debriefing session within 24 hours after use of and/or with staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and 'strategles and/or to be used by the staff, the resident, or others that could others t further αf prevent use . If an injury is sustained by a resident

during the use of and/or , during the debriefing a plan to prevent further injury is to be developed and documented in the medical record.

Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of

facility on

CENTERS FOR MEDICARE & MEDICAID SERVICES

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| | | DATE | | | |

(X2) MULTIPLE CONSTRUCTION COMPLETED A. BUILDING C

10L014 B. WING

04/08/2016

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE

SANDY PINES

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX TAG

TEQUESTA, FL. 33469 PREFD

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (X5) MPLETIO DATE CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)

N 140 ' Continued From page 4

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of documentation that the facility sent the resident receiving facility on

the resident disrupted the unit, instigated peers

accompanied by Law Enforcement officers after

N 140 Continued

Revisions to the

1

Documentation requirements related ta

Expectations for full compliance to the Restraint/Seclusion policy and documentation requirements.

Competency was assessed via post-tests maintained in Individual employee's HR flie. Each employee taking the training was also required to sign an attestation of his/her understanding of the expectations for compliance with established policy and documentation requirements. Nurses were additionally required to complete a correctly completed set of documents to verify understanding of the documentation requirements. Any employee failing to complete training by , 2016 will be required to complete the training before being allowed to return to work.

Monitoring:

The DON/designees and/or the of all documents related to the use of and ongoing on a daily basis to ensure compliance with documentation standards and policy expectations. Aggregated results of the monitoring is reported monthly by the Director

of Nursing to the facility Pi Committee and

quarterly to the Governing Body. Any non-

compliance is addressed through retraining

and/or disciplinary action as appropriate.

100% May 8, 2016

If continuation sheet Page 5 of 48

14:11:05

PRINTED: FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY COMPLETED

10L014

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING _

04/08/2016

MANUF OF PROVIDER OR SUPPLIER

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

| NAME OF PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | |
|------------------------------|--|---------------------|---|--------------------------|--|--|
| ANDY F | INEC | 1 | 11301 SE TEQUESTA TERRACE | | | |
| SAND I FINES | | | TEQUESTA, FL 33469 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (XS) COMPLETO DATE | | |
| N 140 | Continued From page 5 | N 140 | N 140 Continued | | | |
| N 140 | and was not responding to redirection. The resident's record further revealed evidence of documentation that the facility discharged the resident, at that time. Continued review of the resident, at that time. Continued review of the resident's record revealed no evidence of documentation that staff documented the () Intervention in the resident's record, no evidence of documentation that the facility obtained a physician's order for the on | N 140 | For a period of four months, the DON and conducting daily random audits via surveillance camera of each residential unit's area with each area viewed at least 2 time periods each shift. Any incident of observed or is compared with documented / to ensure that all elpisodes are correctly documented. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through certaining and/or disciplinary action as | | | |
| | revealed evidence of documentation that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted | | appropriate. When compliance is maintained for four months, the monitored will be decreased to a sample of each shift weekly. Responsible: | | | |
| | the unit, instigated peers and was not responding to redirection. The resident's record revealed evidence of documentation that the facility re-admitted the resident on and discharged the resident on . Further review of the resident's record revealed no evidence of documentation that staff documented the f .) intervention in the resident's | | Director of Nursing | | | |
| | record, including no evidence of documentation that the facility obtained a physician's order for the of in an interview conducted on at 12:03 PM with the facility's own Risk Manager, the facility's own Risk Manager reported that the facility was a locked facility and the units were also locked and she inquired whether this was a | | | | | |
| N 145 | 483.358(f) ORDERS FOR USE OF OR | N 145 | | | | |

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| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | FORM APPRO | |
|--------------------------|--|---|--------------------|--|--|-----|
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION ING | (X3) DATE SURVE COMPLETED | |
| | | 10L014 | B. WING | | C 04/08/201 | 16 |
| SANDY F | PROVIDER OR SUPPLIER PINES | | | STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE COMPL | LÉΠ |
| N 145 | safety intervention a practitioner trained safety interventions and the facility to as wellb | Initiation of the emergency a physician, or other licensed in the use of emergency and permitted by the state sases the physical and eling of residents, must ace assessment of the | N 1 | 45 N 145 Continued Need to notify the resident's guardian that the resident hand/or document that notification Requirement to conduct document a face to face disc. with all staff and the resident in the staff and th | and and sand ussion volved | |

- resident, including but not limited to-(1) The resident's physical and status:
- (2) The resident's behavior,
- (3) The appropriateness of the intervention measures; and
- (4) Any complications resulting from the intervention.

This ELEMENT is not met as evidenced by: Based on record review, observation and Interview, the facility falled to have a Registered Nurse or Physician conduct a face to face assessment of the resident, to include the required assessments, within one hour of the initiation of a for 2 of 17 sampled residents reviewed for and (Resident #16 and #17).

The findings included:

1. Review on / / of the facility's policies and " with procedures titled, " and the most recent review of / / revealed that the policies and procedures documented that a Registered Nurse (RN) conduct a face to face assessment of the resident within an hour of the

- in an emergency intervention. The discussion must include the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent
- the future use of _______.
 Requirement to complete and document a debriefing session within 24 hours after use of _____ and/or with the staff involved in the emergency safety and appropriate supervisory and administrative staff to review the
- circumstances resulting in the use of and/or and strategles to be used by the staff, the resident, or others that could prevent further use of 1 injury is sustained by a resident during the use of and/or during the debriefing a plan to prevent further injury is to be developed and
- documented in the medical record. Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of _______.

| DEPARTMENT OF HEALTH CENTERS FOR MEDICARE | | · | FORM APPR |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | (X3) DATE SURY COMPLETE |
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| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | A. BUILDING | COMPLETED | |
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| | | 10L014 | B. WING | | 04/08/2016 |
| NAME OF P | PROVIDER OR SUPPLIER | |] - | STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLDBE COMPLET |
| N 145 | Continued From pa | ge 6 | N 145 | N145 Continued | |
| | Within 1 hour of the safety intervention : practitioner trained safety interventions and the facility to as | a initiation of the emergency a physician, or other licensed in the use of emergency and permitted by the state ssess the physical and elng of residents, must | | The DON and and medical records forms related documentation of the use of to ensure that all required element documented correctly and thoroughly | s could be |
| | conduct a face-to-fi | ace assessment of the wellbeing of the | | The DON, , and designees, Corporate Divisional Clinical Director retraining to all nurses, direct attending psychiatrists, and senior lea | s, provided care staff, dership on: |
| | (1) The resident's status; | s physical and | | - Definition of and justification for use of during for an | and/or |
| | (2) The resident | s behavior; | | safety situation - Revisions/clarifications | to the |
| | (3) The approprise measures; and | ateness of the intervention | | Restraint/Seclusion Policy is Who may authorize and/or | the use of |
| | (4) Any complica intervention. | tions resulting from the | | Requirement to physician's order for and/or | any use of |
| | Based on record re interview, the facilit Nurse or Physician assessment of the | not met as evidenced by: avlew, observation and y failed to have a Registered conduct a face to face resident, to include the | | Requirement to con document a face assessment of the later than one hou initiation of the | to face resident no r after the |
| | initiation of a residents reviewed | for seclusions and | | Requirement to fully each use of | document and/or |
| | (Resident #16 and The findings include | • | i | Requirement to documedical record, the safety situation | emergency that |
| | Review on procedures titled, " the most recent revite policies and procedures." | of the facility's policies and and "" with riew of revealed that scedures documented that a | | required/justified th and/or intervenions used, outcome of the interv • Requirement to do | and the ention |

Registered Nurse (RN) conduct a face to face assessment of the resident within an hour of the

| 127-1576 | | | | 14.12.07 | PRINTEU: |
|--------------------------|-----------------------|--|-----------------------------|--|-------------------------------|
| | | AND HUMAN SERVICES | | | FORM APPROV |
| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| SANDY P | INES | | 1 ' | 1301 SE TEQUESTA TERRACE EQUESTA, FL. 33469 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE COMPLET |
| N 145 | Continued From pa | ge 6 | N 145 | N 145 Continued | : |
| | safety intervention : | initiation of the emergency a physician, or other licensed in the use of emergency | | Need to consult resident's treatmen physician for the | t team |

- safety interventions and permitted by the state and the facility to assess the physical and wellbeing of residents, must
 - conduct a face-to-face assessment of the resident, including but not limited to-(1) The resident's physical and status,

wellbeing of the

(2) The resident's behavior;

physical and

- (3) The appropriateness of the Intervention measures; and
- (4) Any complications resulting from the Intervention.

This ELEMENT is not met as evidenced by: Based on record review, observation and Interview, the facility failed to have a Registered Nurse or Physician conduct a face to face assessment of the resident, to include the required assessments, within one hour of the for 2 of 17 sampled initiation of a residents reviewed for seclusions and (Resident #16 and #17).

The findings included:

of the facility's policies and 1. Review on " with procedures titled. " and revealed that the most recent review of the policies and procedures documented that a Registered Nurse (RN) conduct a face to face assessment of the resident within an hour of the

- and to document that consultation including the date/time of the consult.
- Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and to document and/or that evaluation
- Need to notify the resident's legal guardian that the resident had a and/or and
- document that notification Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must include the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent the future use of
 - Requirement to complete and document a debriefing session within 24 hours after use of with and/or ... the staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and 'strategies and/or to be used by the staff, the resident, or others that could

561-427-1576 DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/26/2016 FORM APPROVED OMB NO. 0938-0391

04/08/2016

CENTERS FOR ... EDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED A. BUILDING __ С

10L014

B. WING

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER

SANDY PINES

11301 SE TEQUESTA TERRACE

| SANDY PINES | | | TEQUESTA, FL 33469 | | |
|--------------------------|--|-------|---|---|--|
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | PROVIDER'S PLAN OF CORRECTION FIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | |
| N 145 | Continued From page 7 | N 145 | N 145 Continued | | |
| | Initiation of a or Observations conducted on / at | | /seclusion. If an injury is | | |
| | | | sustained by a resident during the | ! | |
| | approximately 9:25 AM, with the facility's Nurse | | use of and/or . | 1 | |
| | Manager revealed an area that contained two | | during the debriefing a plan to | | |
| | , with doors in place; the doors opened out to a small common area that also | | prevent further injury is to be | 1 | |
| | | | developed and documented in | - | |
| | contained a ; the area was separated | | the medical record. | - | |
| | from a hallway that led to common areas by a set of double doors. The Nurse Manager reported. | | Requirement to obtain and | 1 | |
| | | | document medical treatment | 1 | |
| | during an interview, on / at approximately | | promptly for any injury sustained | į | |
| | 9:25 AM that the facility had taken off the doors to | | by a resident during the use of | ! | |
| | the to avoid seclusions, but re-added them after a revision of their policies | | 11.17 1.11 | | |
| | | | - Revisions to the Restraint/Seclusion | 1 | |
| | Review on / / of the facility's own video | | forms | 1 | |
| | recording revealed Residents #16 and #17 on / at approximately 5:00 PM, locked away | | Documentation requirements related | | |
| | | | to | | |
| | from other residents, in an area that they did not | | - Expectations for full compliance to the | , | |
| | frequent as part of their daily routines. The residents were observed in the area that | | | | |
| | | | documentation requirements. | | |
| | contained the two small , without doors at | | | | |
| | that time, leading into a common area that had a set of locked double doors. The area was void of | | Competency was assessed via post-tests | | |
| | | | maintained in individual employee's HR file. Each | | |
| | any furniture, except for a plastic chair. There | | employee taking the training was also required | 1 | |
| | was a staff member present in the area. The | | to sign an attestation of his/her understanding | 1 | |
| | residents were observed kicking the double doors; the doors did not open when kicked. They | | of the expectations for compliance with | i | |
| | were observed pacing back and forth in the area | | established policy and documentation | | |
| | and this lasted at least 5 minutes. | | requirements. Nurses were additionally | 1 | |
| | Review of Resident #16's record on / / | | required to complete a correctly completed set | 1 | |
| | revealed evidence of documentation that the | | of documents to verify understanding of the documentation requirements. Any employee | | |
| | resident was admitted to the facility on / / | | falling to complete training by , 2016 will | İ | |
| | The resident's record revealed evidence of | | be required to complete the training before | i | |
| | documentation that the facility sent the resident to | | being allowed to return to work. | | |
| | | | news enowed to return to work: | £ | |
| | a receiving facility on / accompanied by Law Enforcement officers after | | | | |
| | the resident disrupted the unit, instigated peers | | | | |
| | and was not responding to redirection and the | | | : | |
| | facility discharged the resident at that time. | | | | |
| | facility discharged the resident at that time. | | | 3 | |

PRINTED: FORM APPROVEI 14:12:51

DEFARTIMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED A. BUILDING __ С B. WING 04/08/2016

NAME OF PROVIDER OR SUPPLIER

10L014

STREET ADDRESS, CITY, STATE, ZIP CODE

| SANDY PINES | | | 11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469 | | |
|--------------------------|--|---------------|--|----------------------------|--|
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | PREFIX TAG | PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| N 145 | Continued From page 8 no evidence of documentation that staff documentation that occumentation that countend the () intervention in the resident's record, including no evidence of documentation that a RN conducted a face to face assessment of the resident within one hour of the initiation of the to include the required assessments. 2. Review of Resident #17's record on | N:14 | | May 8, 2016 and ongoing | |
| N 149 | revealed that the resident was admitted to the facility on . The resident's record documented that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection. The resident's record revealed evidence of documentation that the facility re-admitted the resident on . Further review of the resident's record revealed nevidence of documentation that the facility re-demitted the resident on . Further review of the resident's record revealed ne evidence of documentation that staff documented the (in the resident's record, including no evidence of documentation that a RN conducted a face to face assessment of the resident within one hour of the initiation of the to include the required assessment of the resident within one hour of the initiation of the to include the required assessment of the resident within one hour of the initiation of the to include the required assessment of the resident within one hour of the initiation of the to include the required assessment of the resident within one hour of the initiation of the activity and the units were also locked and she inquired whether this was a 383.359(h) ORDERS FOR USE OF OR | N 14 | compliance is addressed through retraining and/or disciplinary action as appropriate. For a period of four months, the DON and conducting daily random audits via surveiliance camera of each residental units is area with each area viewed at least 2 time periods each shift. Any incident of observed or is compared with documented / to ensure that all episodes are correctly documented. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate. When compliance is animalitance for four months, the monitored will be decreased to a sample of each shift weekly. Responsible: | | |

| | MENT OF HEALTH | AND HUMAN SERVICES & MEDICAID SERVICES | | | FORM | 04/26/2016 APPROVED 0938-0391 |
|--------------------------|--|--|----------------------|-----|--|-------------------------------------|
| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | E CONSTRUCTION (X3) DATE COM | SURVEY |
| | | 10L014 | B. WING | | | 08/2016 |
| SANDY F | PROVIDER OR SUPPLIER | | | 11 | REET ADDRESS, CITY, STATE, ZIP CODE 301 SE TEQUESTA TERRACE EQUESTA, FL 33469 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | ix | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| N 149 | completed by the ei intervention occurs and during the shift documentation mus shift in which it end include all of the foi tribute and in the rest sampled residents (Resident #16 and in the rest sampled residents (Resident #5). The findings including including and procedures till with the most recerbant the policles am Registered Nurse (Justification for each shift. Documentatic the shift during which observations cond approximately 9:25 Manager revealed, w. | of of the shift in which the if the intervention does not in which it began, it which it began, it be completed during the s. Documentation must lowing: not met as evidenced by: wiew, observation and y failed to document a ident's record for 2 of 17 eviewed for the strength of the str | N1 | 149 | Corrective Actions: The Director Nursing (DON) and facility Risk Manager () reviewed and revised the facility policy related to the use and documentation of and | , 2016 |

contained a

; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately

the date/time of the consult.

14:13:58 PRINTED: 04/26/201 FORM APPROVE

| CENTE | RS FOR MEDICARE | & MEDICAID SERVICES | | | | 0 | | 0938-039 |
|--------------------------|--|---|----------------------|-----|--|--|--|--------------------|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (XZ) MUL A. BURLD | | CONSTRUCTION | | | SURVEY |
| | | 10L014 | B. WING | | | | 04/0 | B/2016 |
| SANDY I | PROVIDER OR SUPPLIER PINES | | | 11: | REET ADDRESS, CITY, STATE, 2 301 SE TEQUESTA TERRACE EQUESTA, FL 33469 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC (DENTIFYING INFORMATION) | PREFI | (| PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT | THE APPROP | BE | COMPLETION DATE |
| | Intervention occurs end during the shift documentation mus shift in which it end include all of the fol This ELEMENT is Based on record re interview, the facilit in the res | nd of the shift in which the if the intervention does not in which it began, it be completed during the s. Documentation must | N 1 | 49 | - Requirement to o medical treatmen injury sustained is the use of The DON and medical records forms documentation of the use to ensure that all required documented correctly and to the properties of the proper | and re- related of /s delements of horoughly. signees, alo il Directors, direct cal | for any t during vised all to the seclusion could be ng with provided re staff, | , 201 , 201 |
| | (Resident #16 and | #17) and falled to document a lent's record for 1 of 17 reviewed for ad: i of the facility's own policies td, " and " | | | attending psychiatrists, and Definition of justification for during safety situation Revisions/clarifica Who may a and Requirement physician's 2 | and applied of for an er to obtain the formal er to ob | propriate and/or mergency the uding: e use of stalln a | |
| | hat the policies am Registered Nurse (i Justification for Ret each Stiff: Documentation the shift during while Observations condi- approximately 9:25 Manager revealed a wopened out to a smootalined a from a hallway that of double doors. Tudring an interview, | i procedures documented a RN) to "complete the traint/Seclusion" packet for pisode by the end of the in must be completed within the intervention took place." icted on it AM, with the facility's Nurse an area that contained two the doors in place; the doors all common area that also the area was separated ted to common areas by a set et Nurse Manager reported, | | | Requirement assessment jater than initiation of Requirement each use Requirement medical research safety required/jus | /or to condu a face of the res one hour the t to fully t of t to docume ord, the e situation tified the dd/or s used, | ict and to face iddent no after the and/or document and/or ent in the mergency that use of the and the and the and the | |

PRINTED: 04/26/20 561-427-1576 SEL OLUMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-038 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING . C B. WING 10L014 04/08/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE SANDY PINES TEQUESTA, FL 33469 SUMMARY STATEMENT OF DESICIENCIES PROVIDER'S PLAN OF CORRECTION ID. (X5) COMPLETION DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX N 149 Continued N 149 Continued From page 9 N 149 Requirement to document the completed by the end of the shift in which the names of all staff involved in the Intervention occurs. If the intervention does not and/or end during the shift in which it began, Need to consult with the documentation must be completed during the resident's treatment team shift in which it ends. Documentation must physician for the include all of the following: and and to document that consultation including the date/time of the consult. This ELEMENT is not met as evidenced by: Requirement for an MD or nurse Based on record review, observation and to evaluate the well-being of the Interview, the facility falled to document a resident immediately after the In the resident's record for 2 of 17 resident is removed from sampled residents reviewed for and/or and to document (Resident #16 and #17) and falled to document a that evaluation in the resident's record for 1 of 17 Need to notify the resident's legal sampled residents reviewed for guardian that the resident had a (Resident #5). and/nr document that notification The findings included: Requirement to conduct and document a face to face 1 Review on of the facility's own policies discussion with all staff and the and procedures titled, " resident involved in an emergency with the most recent review of intervention. The discussion must that the policies and procedures documented a include the dirrumstances Registered Nurse (RN) to "complete the resulting in the use of " packet for and/or Justification for and strategles to episode by the end of the be used by the staff, the resident, each or others that could prevent the shift. Documentation must be completed within /seclusion. the shift during which the intervention took place." future use of Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, at approximately during an interview, on 9:25 AM that the facility had taken off the doors to

14:14:21

and procedures titled, " and with the most recent review of revealed that the policies and procedures documented a Registered Nurse (RN) to "complete the /Seclusion" packet for Justification for each episode by the end of the shift. Documentation must be completed within the shift during which the intervention took place." Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two rooms, with doors in place; the doors opened out to a small common area that also : the area was separated from a hallway that led to common areas by a set

of double doors. The Nurse Manager reported,

Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of forms

Revisions to the

- Documentation requirements related to restraint/seclusion
- Expectations for full compliance to the Restraint/Seclusion policy and documentation requirements.

during an interview, on

| PEN LEURO LOU INFOICAUS | & MEDICAID SERVICES | | IND NU. |
|---|---|--|-----------|
| TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | (X3) DATE |
| | | | 1 (|

10L014 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

11301 SE TEQUESTA TERRACE SANDY PINES TEQUESTA, FL 33469

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID m (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) REFIX TAG

N 149 Continued From page 9

completed by the end of the shift in which the intervention occurs. If the intervention does not end during the shift in which it began, documentation must be completed during the shift in which it ends. Documentation must include all of the following:

This ELEMENT is not met as evidenced by: Based on record review, observation and interview, the facility falled to document a In the resident's record for 2 of 17 sampled residents reviewed for (Resident #16 and #17) and falled to document a In the resident's record for 1 of 17 sampled residents reviewed for (Resident #5).

The findings included:

1. Review on of the facility's own policies and procedures titled, " and with the most recent review of revealed that the policies and procedures documented a Registered Nurse (RN) to "complete the Justification for " packet for each seclusion/ episode by the end of the shift. Documentation must be completed within the shift during which the intervention took place." Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also ; the area was separated contained a from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to

N 149 N 149 Continued

Competency was assessed via post-tests maintained in individual employee's HR file. Each employee taking the training was also required to sign an attestation of his/her understanding of the expectations for compliance with policy and documentation established Nurses were additionally requirements. required to complete a correctly completed set of documents to verify understanding of the documentation requirements. Any employee , 2016 will felling to complete training by be required to complete the training before being allowed to return to work.

04/08/2016

14:15:22 PRINTED: 04/26/20 561-427-1576 FORM APPROVI CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-03 STATEMENT OF DEFICIENCIES (X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION A. BUILDING c B. WING 10L014 04/08/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 11301 SE TEQUESTA TERRACE SANDY PINES TEQUESTA, FL 33469 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) N 149 Continued From page 9 N 149 N 149 Continued completed by the end of the shift in which the intervention occurs, if the intervention does not end during the shift in which it began, documentation must be completed during the , 201 shift in which it ends. Documentation must Monitoring include all of the following: and ongoin The DON/designees and/or the RM review 100% of all documents related to the use of on a dally basis to ensure This ELEMENT is not met as evidenced by: compliance with documentation standards and Based on record review, observation and policy expectations. Aggregated results of the interview, the facility falled to document a monitoring is reported monthly by the Director in the resident's record for 2 of 17 of Nursing to the facility PI Committee and sampled residents reviewed for quarterly to the Governing Body. Any non-(Resident #16 and #17) and falled to document a compliance is addressed through retraining in the resident's record for 1 of 17 and/or disciplinary action as appropriate. sampled residents reviewed for (Resident #5). For a period of four months, the DON and conducting daily random audits via surveillance camera of each residential unit's The findings included: area with each area viewed at least 2 1 Review on of the facility's own policies time periods each shift. Any incident of and procedures titled, " and is compared with observed OF with the most recent review of revealed 1 documented to ensure that that the policies and procedures documented a all episodes are correctly documented. Registered Nurse (RN) to "complete the Aggregated results of the monitoring is reported Justification for Restraint/ " packet for monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing J episode by the end of the each shift. Documentation must be completed within Body. Any non-compliance is addressed through the shift during which the intervention took place." retraining and/or disciplinary action appropriate. When compliance is maintained for Observations conducted on at four months, the monitored will be decreased to approximately 9:25 AM, with the facility's Nurse a sample of each shift weekly.

Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, at approximately during an interview, on 9:25 AM that the facility had taken off the doors to

Responsible:

Director of Nursing

If continuation sheet Page 10 of 48

PRINTED: 04/26/2016 FORM APPROVED OMB NO, 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

(X2) MULTIPLE CONSTRUCTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10L014

A. BUILDING_

B. WING

(X3) DATE SURVEY COMPLETED С 04/08/2016

NAME OF PROVIDER OR SUPPLIER

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE

| PLAN OF CORRECTION COMMETTION CONTINUE ACTION SHOULD BE COMMETTION COMMETT |
|--|
| he well-being of the resident ly after the resident is from and/or and to document that |
| he well-being of the resident ly after the resident is from and/or and to document that |
| he well-being of the resident ly after the resident is from and/or and to document that |
| ely after the resident is from and/or and to document that |
| from and/or and to document that |
| and to document that |
| 1 |
| |
| |
| that the resident had a |
| and/or and |
| that notification |
| ent to conduct and |
| t a face to face discussion |
| taff and the resident involved |
| nergency intervention. The |
| n must include the |
| nces resulting in the use of |
| and/or and |
| to be used by the staff, the |
| or others that could prevent |
| euse of / , , , |
| ent to complete and |
| t a debriefing session within |
| after use of and/or |
| with the staff involved in the |
| cy safety and/or |
| and appropriate supervisory |
| inistrative staff to review the |
| and/or and |
| s to be used by the staff, the |
| or others that could prevent |
| se of / If an |
| sustained by a resident during |
| of and/or |
| e debriefing a plan to prevent |
| njury is to be developed and |
| ited in the medical record. |
| |
| |
| |

| 1-427-1576 DEPARTMENT OF HEALTH CENTERS FOR MEDICARE | | 14:15:44 | | RINTED: 04/26/2016 FORM APPROVED MB NO. 0938-0391 |
|--|---|--|----------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED |
| | 10L014 | B. WING | | C 04/08/2016 |
| NAME OF PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE. | ZIP CODE | |

11301 SE TEQUESTA TERRACE

| SANDY PINES | | | TEQUESTA, FL 33469 | | |
|--------------------------|---|---------------------|--|-------------------|--|
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | COMPLETIO DATE | |
| N 149 | Continued From page 11 | N 14 | 9 | | |
| | the resident disrupted the unit, instigated peers and was not responding to redirection. The resident's record revealed evidence of | | | : | |
| | documentation that the facility re-admitted the resident on and discharged the resident | | ! | | |
| | on Further review of the resident's record revealed no evidence of documentation | | | | |
| | that staff documented the intervention in the resident's record. | | | 22.0 | |
| | with the facility's Risk Manager, the facility's Risk Manager reported that the facility was a locked | | | | |
| | facility and the units were also locked and she inquired whether this was a | | ļ | | |
| | 3 Review on of Resident #5's record | | | i i | |
| | revealed evidence of documentation of a on at 3:30 PM and the resident accused | | 1 | | |
| | staff of spitting on the resident. The resident's record revealed evidence of documentation of a | | | i | |
| | "monthly district staffing," dated that documented the resident was "restrained | | | | |
| | yesterday" and no additional information/packet documentation related to the intervention. | | | | |
| | During a review on at approximately 4:45 PM, of the facility's video recording of the | | | | |
| | occurrence and Interview with the facility's Risk Manager, the facility's Risk Manager reported that | | | 1 | |
| | she could not locate any video recording of the occurrence or additional information. In an | | | | |
| | Interview conducted on at 12:03 PM with the facility's Risk Manager, the facility's Risk Manager acknowledged the finding. | | | i | |
| N 152 | 483.358(h)(3) ORDERS FOR USE OF | N 15 | 2 | | |

14:16:02 05-06-2016

PRINTED: 04/28/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

B. WING

(X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

10L014

A. BUILDING

(X3) DATE SURVEY COMPLETED 04/08/2016

NAME OF PROVIDER OR SUPPLIER

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE

SANDY PINES TEQUESTA, FL 33489 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID PREFIX TAG CKS COMPLETION PREFIX DEFICIENCY N 152 Continued From page 12 . 2016 N 152 Corrective Actions: [Documentation must include] the time and The Director Nursing (DON) and facility Risk results of the 1-hour assessment required in Manager () reviewed and revised the facility paragraph (f) of this section. policy related to the use and documentation of and and to ensure that are required elements are This ELEMENT is not met as evidenced by: included and clearly stated for staff Based on record review, observation and interpretation. Key elements of the policy interview, the facility falled to have a Registered include: Nurse or Physician conduct a face to face Clarification on the definition of assessment of the resident within one hour of the and to include the required initiation of a Who may authorize the use of time and results of the assessment, for 2 of 17 and/or and sampled residents reviewed for Requirement to obtain a physician's (Resident #16 and #17). order for any use of and/or The findings included: Requirement to conduct document a face to face assessment of Review on / of the facility's policies and procedures titled, " and "w Review on the resident no later than one hour the most recent review of the policies and " with after the initiation of the / revealed that and/or the policies and procedures documented a Requirement to fully document each use of and/or Registered Nurse (RN) to conduct a face to face Requirement to document in the assessment of the resident within an hour of the medical record, the emergency safety initiation of a OF / at situation that required/justified the Observations conducted on use of and/or , the approximately 9:25 AM, with the facility's Nurse interventions used, and the outcome Manager revealed an area that contained two of the intervention , with doors in place; the doors - Requirement to document the names opened out to a small common area that also of all staff involved in the ; the area was separated contained a and/or from a hallway that led to common areas by a set Need to consult with the resident's of double doors. The Nurse Manager reported, treatment team physician for the during an interview, on 1 1 at approximately and and to 9:25 AM that the facility had taken off the doors to document that consultation including the to avoid , but the date/time of the consult. re-added them after a revision of their policies. Review on / / of the facility's own video

recording revealed Residents #16 and #17 on

561-427-1576 *TEALITIAND HUMAN SERVICES* CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C 101 014 04/08/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE SANDY PINES TEQUESTA, FL 33469 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (D) (XIS) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) N 152 Continued N 152 Continued From page 12 N 152 Requirement for an MD or nurse to [Documentation must include] the time and evaluate the well-being of the resident results of the 1-hour assessment required in immediately after the resident is paragraph (f) of this section. removed from and/or and to document that evaluation This ELEMENT is not met as evidenced by: Need to notify the resident's legal Based on record review, observation and guardian that the resident had a interview, the facility falled to have a Registered and/or Nurse or Physician conduct a face to face document that notification assessment of the resident within one hour of the to conduct Requirement initiation of a to include the required document a face to face discussion with all staff and the resident involved time and results of the assessment, for 2 of 17 sampled residents reviewed for in an emergency intervention. The discussion must include the (Resident #16 and #17). circumstances resulting in the use of and and/or The findings included: strategies to be used by the staff, the review on of the facility's policies and procedures titled, " resident, or others that could prevent the future use of " with Requirement to complete and the most recent review of revealed that document a debriefing session within the policies and procedures documented a and/or 24 hours after use of Registered Nurse (RN) to conduct a face to face with the staff involved in the emergency safety

assessment of the resident within an hour of the initiation of a Observations conducted on . at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also ; the area was separated contained a from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to , but to avoid the re-added them after a revision of their policies. Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away

injury sustained by a resident during the use of Facility ID: RC57000080P

and appropriate supervisory

- /

and administrative staff to review the

circumstances resulting in the use of

strategies to be used by the staff, the

resident, or others that could prevent

injury is sustained by a resident during

during the debriefing a plan to prevent

further injury is to be developed and

Requirement to obtain and document

medical treatment promptly for any

documented in the medical record.

and/or

further use of

the use of

AND PLAN OF CORRECTION

SANDY PINES

(X4) ID PREFIX

TAG

14:16:47

PRINTED: FORM APPROVE OMB NO. 0938-039

(X3) DATE SURVEY COMPLETED C 04/08/2016

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER

(X2) MULTIPLE CONSTRUCTION A. BUILDING

B. WING

NAME OF PROVIDER OR SUPPLIER

10L014

STREET ADDRESS, CITY, STATE, ZIP CODE 11391 SE TEQUESTA TERRACE

TEQUESTA, FL 33469

N 152 Continued

PROVIDER'S PLAN OF CORRECTION

N 152 Continued From page 12 [Documentation must include] the time and

in (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIATE TAG

N 152

(X5) COMPLETION DATE

, 201

, 2016

results of the 1-hour assessment required in paragraph (f) of this section.

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION)

This ELEMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to have a Registered Nurse or Physician conduct a face to face assessment of the resident within one hour of the Initiation of a to include the required time and results of the assessment, for 2 of 17 sampled residents reviewed for

(Resident #16 and #17).

The findings included:

review on of the facility's policies and procedures titled, " the most recent review of revealed that the policies and procedures documented a Registered Nurse (RN) to conduct a face to face assessment of the resident within an hour of the initiation of a or Observations conducted on approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to to avoid , but re-added them after a revision of their policies. of the facility's own video Review on

recording revealed Residents #16 and #17 on

at approximately 5:00 PM, locked away

The DON and RM reviewed and revised all medical records forms related to the documentation of the use of /seclusion to ensure that all required elements could be documented correctly and thoroughly. , and designees, along with E The DON, Corporate Divisional Clinical Directors, provided

DEFICIENCY

retraining to all nurses, direct care staff, attending psychiatrists, and senior leadership on: Definition of and appropriate justification for use of ... and/or during for an emergency safety situation

Revisions/clarifications to Policy including: 1

Who may authorize the use of and/or Requirement to obtain

physician's order for any use of and/or . Requirement to conduct and document a face to face assessment of the resident no later than one hour after the .: and/or initiation of the

Requirement to fully document and/or each use of ...

Requirement to document in the medical record, the emergency situation that safety required/justifled the use of , the and/or interventions used, and the outcome of the intervention Requirement to document the names of all staff involved in the

and/or

from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, at approximately during an interview, on 9:25 AM that the facility had taken off the doors to

re-added them after a revision of their policies. of the facility's own video

recording revealed Residents #16 and #17 on

to avoid seclusions, but

Facility ID: RC57000060P

the

14:17:30

PRINTED:

| OI | NO. | | |
|----|------|--|--|
| | DATE | | |

39 COMPLETED

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING

> 10L014 B. WING

C 04/08/2016

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SANDY PINES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469

(X4) ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)

use of

(X5) MPLETION DATE

N 152 Continued From page 12

[Documentation must include] the time and results of the 1-hour assessment required in paragraph (f) of this section.

SUMMARY STATEMENT OF DEFICIENCIES

This ELEMENT is not met as evidenced by: Based on record review, observation and interview, the facility falled to have a Registered Nurse or Physician conduct a face to face assessment of the resident within one hour of the Initiation of a to include the required time and results of the assessment, for 2 of 17 sampled residents reviewed for (Resident #16 and #17).

The findings included:

review on of the facility's policies and procedures titled, " the most recent review of " with revealed that the policies and procedures documented a Registered Nurse (RN) to conduct a face to face assessment of the resident within an hour of the Initiation of a 101 Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also the area was separated; contained a from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, at approximately during an interview, on 9:25 AM that the facility had taken off the doors to the to avoid i. but re-added them after a revision of their policies. of the facility's own video recording revealed Residents #16 and #17 on

N 152 N 152 Continued

document a debriefing session within 24 hours after use of and/or with staff involved in the emergency safety and/or appropriate and supervisory and administrative staff to review the circumstances resulting in the use of and/or and 'strategles to be used by the staff, the resident, or others that could prevent further use of

Requirement to complete and

during the debriefing a plan to prevent further injury is to be developed and documented in the medical record. Requirement to obtain and

/seclusion. If an injury is sustained by a resident during the

and/or

document medical treatment? promptly for any injury sustained. by a resident during the use of

Revisions to the forms

Documentation regulrements related /seclusion

Expectations for full compliance to the policy documentation requirements.

PRINTED: 04/26/20

561-427-1576 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVE OMB NO. 0938-038 CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING C B. WING 10L014 04/08/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE

SANDY PINES

TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)

IO REFD

TEQUESTA, FL 33469 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE

(X5) APLETION DATE

N 152 Continued From page 12

[Documentation must include] the time and results of the 1-hour assessment required in paragraph (f) of this section.

This ELEMENT is not met as evidenced by: Based on record review, observation and interview, the facility falled to have a Registered Nurse or Physician conduct a face to face assessment of the resident within one hour of the initiation of a to include the required time and results of the assessment, for 2 of 17 sampled residents reviewed for and (Resident #16 and #17).

The findings included:

Review on

neview on of the facility's policies and procedures titled, " " with revealed that the most recent review of the policies and procedures documented a Registered Nurse (RN) to conduct a face to face assessment of the resident within an hour of the initiation of a Or Observations conducted on approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also ; the area was separated contained a from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, at approximately during an interview, on 9:25 AM that the facility had taken off the doors to to avoid seclusions, but re-added them after a revision of their policies. Review on of the facility's own video recording revealed Residents #16 and #17 on

N 152 N 152 Continued

Competency was assessed via post-tests maintained in individual employee's HR file. Each employee taking the training was also required to sign an attestation of his/her understanding of the expectations for compliance with established policy and documentation Nurses were additionally requirements. required to complete a correctly completed set of documents to verify understanding of the documentation requirements. Any employee , 2016 will falling to complete training by be required to complete the training before being allowed to return to work.

FORM CMS-2587(02-99) Previous Versions Obsolete

at approximately 5:00 PM, locked away Event ID: TIBR11

Fee:16by 10: RC570000R0P

If continuation sheet Page 13 of 48

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & ...EDICAID SERVICES

14:18:11 PRINTED: 04/26/2016 FORM APPROVED OMB NO. 0938-0391

(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING _

10L014

04/08/2016

NAME OF PROVIDER OR SUPPLIER

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

STREET ADDRESS, CITY, STATE, ZIP CODE

| SANDY PINES | | | 11301 SE TEQUESTA TERRACE TEQUESTA, FL. 33469 | | |
|--------------------------|--|---------------------|--|----------------------------|--|
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| N 152 | Continued From page 13 | N 15 | 2 N 152 Continued | 1 | |
| | from other residents, in an area that they did not | | | | |
| fre | frequent as part of their dally routines. The | | ! | | |
| | residents were observed in the area that | | | 8, 201 | |
| | contained the two small . without doors at | | Monitoring: | and ongoin | |
| | that time, leading into a common area that had a | | A Company of the Comp | J 5 | |
| | set of locked double doors. The area was void of | | The DON/designees and/or the 100% | | |
| | any furniture, except for a plastic chair. There | | of all documents related to the use of | 1 | |
| | was a staff member present in the area. The | | /seclusion on a daily basis to ensure | - | |
| | residents were observed kicking the double | | compliance with documentation standards and | ; | |
| | doors; the doors did not open when kicked. They | | policy expectations. Aggregated results of the | 1 | |
| | were observed pacing back and forth in the area | | monitoring is reported monthly by the Director | 1 | |
| | and this lasted at least 5 minutes. | | of Nursing to the facility PI Committee and | 1 | |
| | Review of Resident #16's record on / / | | quarterly to the Governing Body. Any non- | 1 | |
| | revealed evidence of documentation that the | | compliance is addressed through retraining | ; | |
| | resident was admitted to the facility on 1/ 1. | | and/or disciplinary action as appropriate. | 1 | |
| | The resident's record revealed evidence of | | : | i | |
| | documentation that the facility sent the resident to | | For a period of four months, the DON and conducting daily random audits via | | |
| | a receiving facility on / | | surveillance carners of each residential unit's | 1 | |
| | accompanied by Law Enforcement officers after | | surveillance camera or each residential drift's area with each area viewed at least 2 | | |
| | the resident disrupted the unit, instigated peers | | time periods each shift. Any incident of | | |
| | and was not responding to redirection and the | | observed or is compared with | | |
| | facility discharged the resident at that time. | | documented seclusion/ to ensure that | | |
| | Further review of the resident's record revealed | | all episodes are correctly documented | | |
| | no evidence of documentation that staff | | Aggregated results of the monitoring is reported | | |
| | documented the () intervention in the | | monthly by the Director of Nursing to the facility | , 1 | |
| | resident's record, including no evidence of | | Pi Committee and quarterly to the Governing | | |
| | documentation that a RN conducted a face to | | Body. Any non-compliance is addressed through | | |
| | face assessment of the resident within one hour | | retraining and/or disciplinary action as | s ! | |
| | of the initiation of the , to include the | | appropriate. When compliance is maintained for | r i | |
| | required time and results of the assessment. | | four months, the monitored will be decreased to |) ! | |
| 2. Re revea | required line and results of the assessment. | | a sample of each shift weekly. | | |
| | 2. Review of Resident #17's record on / / | | 1 ' | i | |
| | revealed that the resident was admitted to the | | Responsible: | | |
| | facility on / / The resident's record | | | | |
| | documented that the facility sent the resident to a | | Director of Nursing | į | |
| | receiving facility on / | | | | |
| | accompanied by Law Enforcement officers after | | • | ; | |
| | | | | | |
| | the resident disrupted the unit, instigated peers | | | | |

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

561-427-1576 DEPARTMENT OF HEALTH AND HUMAN SERVICES

14:18:34 PRINTED: 04/26/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY COMPLETED

CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING __

| | | 10L014 | B, WING | | 04/08/2016 |
|--------------------------|--|--|---------------------|---|--|
| NAME OF F | PROVIDER OR SUPPLIER PINES | | 1 | STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE TEQUESTA, FL. 33469 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | COMPLETION E DATE |
| N 152 | Continued From pi resident's record re documentation that resident on . Further record revealed nc that staff documen in the resident's re documentation that face assessmot of the initiation of the initiation of the initiation of the required time and in an interview cor with the facility 8 reported that the faunts were also loc this was a 483.358(h)(4) ORI OR IDocumentation m safety situation the restrained or put in This ELEMENT is Based on record interview, the facility 8. | sign 14 availed evidence of the facility re-admitted the and discharged the resident review of the resident's evidence of documentation ted the () intervention ted the () intervention ord, including no evidence of ta RN conducted a face to the resident within one hour he , to include the results of the assessment, ducted on at 12.03 PM ske Manager, the Risk Manager cellity was a locked facility, the ked and she inquired whether stern of the resident to be use tinclude) the emergency t required the resident to be not met as evidenced by eview, observation and y failed to document the situation that required the 7 sampled residents | N 152 | Corrective Actions: The Director Nursing (DON) and facility F Manager () reviewed and revised the facility related to the use and documentation and and clearly stated for so interpretation. Key elements of the policide: Clarification on the definition and Who may authorize the use of and/or | , 20 liky lity of , " erer art lity of |
| : | The findings include Review on and procedures title with the most rece | of the facility's own policies ed, " and "" | | diday for any over | l/or and t of |

14:18:54 PRINTED: 04/26/2016 FORM APPROVED OMB NO. 0938-0391

| | | AND HUMAN SERVICES | | | - | | APPROVE |
|--------------------------|---------------------------------|--|----------------------|----|--|----------|--------------------|
| | | & MEDICAID SERVICES | | | | | 0938-039 |
| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | E CONSTRUCTION | COM | SURVEY PLETED |
| | | 10L014 | B. WING | _ | | |) 08/2016 |
| NAME OF F | PROVIDER OR SUPPLIER | | - (| S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| SANDY F | mure. | | ĺ | 11 | 1301 SE TEQUESTA TERRACE | | |
| SANDTF | | | | T | EQUESTA, FL 33469 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | STEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFD TAG | ĸ | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | COMPLETION DATE |
| | | | | | N 153 Continued | | |
| N 153 | Continued From pa | ige 15 | N 1 | 53 | | | |
| | Registered Nurse (| RN) to "complete the | | | - Requirement to fully docume | | |
| | Justification for Res | straint/ packet on | | | use of and/or | | |
| | each / | episode by the end of the | | | Requirement to document medical record, the emergence | | 1 |
| | shift. Documentation | on must be completed within | | | situation that required/justif | | |
| | the shift during whi | ch the intervention took place." | | | use of and/or | the | |
| | Review of the "Just | lification for | | | interventions used, and the o | | ; |
| | | " sample document on | | | of the intervention | diconse | |
| | revealed th | at the document required staff | 1 | | - Regulrement to document the | names | ! |
| | to complete the "No | ursing | | | of all staff involved in the | | ì |
| | Note/Rational/Justi | | i | | and/or | | ! |
| | ()Interven | ition" section of the packet. | | | - Need to consult with the re | sident's | |
| | Observations cond | | ı | | treatment team physician | | |
| | | AM, with the facility's Nurse | | | and is | | ł |
| | | an area that contained two | | | document that consultation i | ncluding | |
| | | ith doors in place; the doors | | | the date/time of the consult. | | |
| | | nall common area that also | | | - Requirement for an MD or I | | 1 |
| | contained a | ; the area was separated | | | evaluate the well-being of the | | |
| | | led to common areas by a set | | | immediately after the resi removed from | and/or | |
| | | ne Nurse Manager reported, | | | and to docume | | |
| | during an interview | | | | evaluation | | 1 |
| | | cility had taken off the doors to to avoid , but | | | Need to notify the resident | 's legal | ĺ |
| | the | | : | | guardian that the resident | | i |
| | | er a revision of their policies. of the facility's own video | 1 | | and/or | | |
| | | Residents #16 and #17 on | | | document that notification | | 1 |
| | | nately 5:00 PM, locked away | i | | - Requirement to conduc | | |
| | | s, in an area that they did not | 1 | | document a face to face di | | |
| | | their daily routines. The | ! | | with all staff and the resident | | ļ |
| | | erved in the area that | | | in an emergency intervention | | |
| | contained the two | | i | | discussion must include | | |
| | | nto a common area that had a | | | circumstances resulting in the | | |
| | set of locked doubl | e doors. The area was void of | | | strategies to be used by the s | | |
| | any furniture, excer | pt for a plastic chair. There | | | resident, or others that could | | |
| | was a staff member | er present in the area. The | | | the future use of | prevent | |
| | residents were obs | erved kicking the double | | | the receive one of | | |
| | doors; the doors di | d not open when kicked. They | | | | | |
| | were observed page | ing back and forth in the area | | | 1 | | 1 |
| | and this lasted at le | | | | | | i r |
| | Review of Residen | t #16's record on | | | | | ! |
| | | | | | | | |

14:19:17 561-427-1576 PRINTED: 04/26/201 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVE CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A BUILDING C 10L014 04/08/2016 NAME OF PROVIDER OR SUPPLIES STREET ADDRESS CITY STATE ZIP CODE 11301 SE TEQUESTA TERRACE SANDY PINES TEQUESTA, FL 33469 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID m (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG N 153 Continued N 153 Continued From page 15 N 153 Requirement to complete and Registered Nurse (RN) to "complete the document a debriefing session within Justification for Restraint/Seclusion packet on 24 hours after use of and/or each seclusion/ episode by the end of the with the staff involved in the shift, Documentation must be completed within emergency safety and/or the shift during which the intervention took place." and appropriate supervisory Review of the "Justification for and administrative staff to review the Restraint/Seclusion" sample document on circumstances resulting in the use of revealed that the document required staff and/or and to complete the "Nursing strategies to be used by the staff, the Note/Rational/Justification for resident, or others that could prevent (seclusion)Intervention" section of the packet. further use of restraint/ injury is sustained by a resident during Observations conducted on at approximately 9:25 AM, with the facility's Nurse the use of and/or Manager revealed an area that contained two during the debriefing a plan to prevent further injury is to be developed and , with doors in place; the doors documented in the medical record. opened out to a small common area that also Requirement to obtain and document contained a ; the area was separated medical treatment promptly for any from a hallway that led to common areas by a set injury sustained by a resident during of double doors. The Nurse Manager reported, the use of 1 at approximately during an interview, on 9:25 AM that the facility had taken off the doors to , 2016 The DON and and revised all the to avoid seclusions, but medical records forms related to the re-added them after a revision of their policies. documentation of the use of /seclusion of the facility's own video Review on to ensure that all required elements could be recording revealed Residents #16 and #17 on documented correctly and thoroughly. at approximately 5:00 PM, locked away , and designees, along with May 8, 2016 The DON.

from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that , without doors at contained the two small that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area

Corporate Divisional Clinical Directors, provided retraining to all nurses, direct care staff, attending psychiatrists, and senior leadership on: Definition of and appropriate justification for use of and/ot during for an emergency

safety situation Revisions/clarifications Restraint/Seclusion Policy Including:

. Who may authorize the use of and/or

If continuation sheet Page 16 of 48

and this lasted at least 5 minutes. Review of Resident #16's record on STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

SANDY PINES

(X4) ID PREFIX

NAME OF PROVIDER OR SUPPLIER

561-427-1576 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/26/201 FORM APPROVE OMB NO. 0938-039 (X3) DATE SURVEY C

04/08/2016

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

10L014

STREET ADDRESS, CITY, STATE, ZIP CODE

11381 SE TEQUESTA TERRACE

TEQUESTA, FL 33469

PROVIDERS PLAN OF CORRECTION (XS) MPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

N 153 Continued From page 15

Registered Nurse (RN) to "complete the Justification for packet on each sedusion/ episode by the end of the shift. Documentation must be completed within the shift during which the intervention took place." Review of the "Justification for " sample document on

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

revealed that the document required staff to complete the "Nursing Note/Rational/Justification for (seclusion)Intervention" section of the packet. Observations conducted on approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported. during an interview, on at approximately 9:25 AM that the facility had taken off the doors to to avoid , but the re-added them after a revision of their policies.

of the facility's own video

recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their dally routines. The residents were observed in the area that , without doors at contained the two small that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area

N 153 Continued N 153

PREEIX

- Requirement to obtain a physician's order for any use of and/or_
- Requirement to conduct and document a face to face assessment of the resident no later than one hour after the and/or initiation of the
- Regulrement to fully document and/or each use of
- Requirement to document in the medical record, the emergency situation safety required/justifled the use of and/or , the Interventions used, and the
- outcome of the Intervention Requirement to document the names of all staff involved in the and/or
- Need to consult with the resident's treatment team physician for the and and to document that consultation Including date/time of the consult.
 - Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and/or and to document
- that evaluation Need to notify the resident's legal guardian that the resident had a and/or and
 - document that notification

and this lasted at least 5 minutes. Review of Resident #16's record on

Review on

| | | | | | | 14:20:04 | | |
|--------------------------|--|--|-----------|-----|----------------------------|--|--|-----------------------------------|
| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | | FORM | 04/26/201 APPROVEI 0938-039 |
| TATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDENSUPPLIENCLIA IDENTIFICATION NUMBER: | (X2) MULT | | CONSTRUCTION | N | (X3) DATE | SURVEY PLETED |
| | | 10L014 | B. WING | | | | | D8/2016 |
| NAME OF F | PROVIDER OR SUPPLIER | | 1 | 6TR | WEET ADDRESS, | CITY, STATE, ZIP CODE | | |
| SANDY F | PINES | | | | 01 SE TEQUE! QUESTA, FL | STA TERRACE 33469 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIT | | (EACH CO | DER'S PLAN OF CORRECTIVE ACTION SHO FERENCED TO THE APPL DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| | | | | N | 153 Continu | ied | | |
| N 153 | Continued From pa | ge 15 | N 1 | 53 | | | | |
| | Justification for each / shift. Documentation the shift during which Review of the "Just /Seciusion revealed the to complete 4he "No. Note/Rational/Justific (seciusion)Interven Observations cond approximately 9:25 Manager revealed | n" sample document on a the document required staff ursing floation for lion" section of the packet, ucted on a lat AM, with the facility's Nurse an area that contained two | | | | resulting in the use and/or and be used by the staff, or others that could future use of Requirement to co document a debrie within 24 hours at and/or | to face taff and the nemergency sussion must recurstances of strategies to the resident, prevent the / mplete and fing session fiter use of with | |
| | opened out to a sm contained a from a hallway that of double doors. The during an interview 9:25 AM that the father than the cadded them after Review on recording revealed at approxin from other resident frequent as part of | with doors in place; the doors all common area that also it has area was separated led to common areas by a set the Nurse Manager reported, on at approximately couldly had taken off the doors to to avoid put a revision of their policies. of the facility's own video Residents #17 on nately \$5.00 PM, locked away s, in an area that they did not their daily routines. The | | | | to be used by the resident, or others prevent further | and/or appropriate dministrative ircumstances of d 'strategies e staff, the that could use of if n nijury is if nt during the 'or ig a plan to | |

residents were observed in the area that

contained the two small , without doors at that time, leading into a common area that had a

set of locked double doors. The area was void of

doors; the doors did not open when kicked. They were observed pacing back and forth in the area

any furniture, except for a plastic chair. There was a staff member present in the area. The

residents were observed kicking the double

developed and documented in

document medical treatment

promptly for any injury sustained by a resident during the use of

the medical record. · Requirement to obtain and

restraint/seclusion

14:20:27 561-427-1576 PRINTED: 04/26/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVE CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING C 10L014 04/08/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 11301 SE TEQUESTA TERRACE SANDY PINES TEQUESTA, FL 33469 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT (X4) ID PREFIX ID (XIS) VPLETION DATE PREFIX TAG DEFICIENCY) N 153 Continued N 153 Continued From page 15 Registered Nurse (RN) to "complete the Revisions to the 1 Justification for Restraint/Seclusion packet on each episode by the end of the Documentation requirements related shift. Documentation must be completed within tn the shift during which the intervention took place." Expectations for full compliance to the Review of the "Justification for policy " sample document on documentation requirements. revealed that the document required staff to complete the "Nursing Competency was assessed via post-tests Note/Rational/Justification for maintained in Individual employee's HR file. Each (seclusion)Intervention" section of the packet. employee taking the training was also required Observations conducted on at to sign an attestation of his/her understanding approximately 9:25 AM, with the facility's Nurse of the expectations for compliance with Manager revealed an area that contained two and documentation established policy , with doors in place; the doors Nurses were additionally requirements. required to complete a correctly completed set opened out to a small common area that also ; the area was separated of documents to verify understanding of the contained a from a hallway that led to common areas by a set documentation requirements. Any employee , 2016 will failing to complete training by of double doors. The Nurse Manager reported, be required to complete the training before during an interview, on at approximately 9:25 AM that the facility had taken off the doors to being allowed to return to work. to avoid seclusions, but the re-added them after a revision of their policies. of the facility's own video Review on recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The

Review of Resident #16's record on FORM CMS-2567(02-99) Previous Versions Obsolete

residents were observed in the area that

that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes

contained the two small

Event ID: TIBR11

, without doors at

Facility ID: RC57000080P

If continuation sheet Page 16 of 48

14:20:49

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

(X2) MULTIPLE CONSTRUCTION

PRINTED: 04/26/201 FORM APPROVE OMB NO. 0938-039

(X3) DATE SURVEY COMPLETED

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10L014

A. BUILDING

B. WING ___

04/08/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

| NAME OF | PROVIDER OR SUPPLIER | 1 | STREET ADDRESS, CITY, STATE, ZIP CODE | |
|--------------------------|--|---------------------|--|--------------------|
| | -11.150 |] 1 | 1301 SE TEQUESTA TERRACE | |
| SANDY I | PINES | 1 | TEQUESTA, FL 33469 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | COMPLETION DATE |
| N 153 | Continued From page 16 | 11.450 | N 153 Continued | |
| 14 133 | | N 103 | W 133 COMMA | į. |
| | revealed evidence of documentation that the | | | 1 |
| | resident was admitted to the facility on | | f., | , 20 |
| | The resident's record revealed evidence of | | Monitoring: | |
| | documentation that the facility sent the resident to | | The DON/designees and/or the 100% | and ongo |
| | a receiving facility on accompanied by Law Enforcement officers after | | of all documents related to the use of | t l |
| | the resident disrupted the unit, instigated peers | | / on a daily basis to ensure | |
| | and was not responding to redirection and the | | compliance with documentation standards and | i |
| | facility discharged the resident at that time. | | policy expectations. Aggregated results of the | 1 |
| | Further review of the resident's record revealed | | monitoring is reported monthly by the Director | i |
| | no evidence of documentation that staff | | of Nursing to the facility Pi Committee and | f. |
| | documented the emergency safety situation that | | quarterly to the Governing Body. Any non- | |
| | regulared the intervention in the | | compliance is addressed through retraining | 1 |
| | resident's record. | | and/or disciplinary action as appropriate. | |
| | 2. Review of Resident #17's record on | | For a period of four months, the DON and conducting daily random audits via | f |
| | revealed that the resident was admitted to the | | surveillance camera of each residential unit's | |
| | facility on . The resident's record | | area with each area viewed at least 2 | , |
| | documented that the facility sent the resident to a | | time periods each shift. Any incident of | 1 |
| | receiving facility on | | observed or is compared with | |
| | accompanied by Law Enforcement officers after | | documented seclusion/ to ensure that | |
| | the resident disrupted the unit, instigated peers | | all episodes are correctly documented. | 1 |
| | and was not responding to redirection. The | | Apprenated results of the monitoring is reported | 1 |
| | resident's record revealed evidence of | | monthly by the Director of Nursing to the facility | |
| | documentation that the facility re-admitted the | | Pi Committee and quarterly to the Governing | i |
| | resident on and discharged the resident | | Body. Any non-compliance is addressed through | , |
| | on . Further review of the resident's | | retraining and/or disciplinary action as | |
| | record revealed no evidence that staff | | appropriate. When compliance is maintained for | 1 |
| | documented the emergency safety situation that | | four months, the monitored will be decreased to | 1 |
| | required the Intervention in the | i | a sample of each shift weekly. | |
| | resident's record. | | Responsible: | 1 |
| | In an interview conducted on at 12:03 PM | | Meshousine: | |
| | with the facility's Risk Manager, the Risk Manager | ; | Director of Nursing | |
| | reported that the facility was a locked facility; the | 1 | - Director or reasoning | |
| | units were also locked and she inquired whether | | | 1 |
| | this was a | N 15 | 4 | 1 |
| N 154 | 483.358(h)(5) ORDERS FOR USE OF | . (4)15 | * | 1 |

OR

Pacility ID: RC57000050P

PRINTED: 04/26/2016 FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING __

(X3) DATE SURVEY COMPLETED С 04/08/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

| | | 10L014 | B. WING | | | 04/0 | 8/2016 |
|--------------------------|---|---|---------------|------------|---|--------------------|---------------------------|
| IAME OF | PROVIDER OR SUPPLIER | | | STREET AD | DRESS, CITY, STATE, ZIP CODE | | |
| | | | | 11301 SE T | EQUESTA TERRACE | | |
| SANDY F | INES | | - 1 | TEQUEST | TA, FL 33469 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (E CRC | PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD DSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETIC DATE |
| N 154 | Continued From pa | ge 17 | N 1 | 54 | | 1 | |
| | | ust include] the name of staff | | Correct | ive Actions: | : | , 20 |
| | HIVOIVEZ III GIO GIIIC | rgericy among theory at morn. | | Manage | rector Nursing (DON) and facili er () reviewed and revised the | facility | |
| i | | not met as evidenced by: eview, observation and | | policy r | elated to the use and documenta and " and | tion of | |
| | interview, the facilit | y falled to document in the | | | ure that are required element d and clearly stated for | | |
| | members involved | | | interpre | etation. Key elements of the | policy | |
| | | reviewed for and the things and the things and the things and the things are the things and the things are the things and the things are the | | - | Clarification on the definition | on of | |
| | The findings include | ted: | | - | Who may authorize the use of and/or | | |
| | 1. Review on | of the facility's own policies | | | Requirement to obtain a phy order for any use of | sician's and/or | |
| | and procedures title with the most recer | nt review of revealed | | | Requirement to conduct | and | |
| | Registered Nurse (| d procedures documented a RN) to "complete the | | | document a face to face assess the resident no later than or | | |
| | Justification for each | /Seclusion packet on episode by the end of the | | | after the initiation of the | | |
| | shift, Documentation | on must be completed within the intervention took place." | | | Requirement to fully document use of and/or | ŧ , | |
| | Review of the "Just | | | 1 | Requirement to document medical record, the emergence | safety | |
| | revealed th | at the document required staff imes of the participants in the | | ì | situation that required/justifi use of and/or | | |
| | intervention. | miles of the participants in the | | i | interventions used, and the o of the intervention | | |
| | Observations cond | ucted on at AM, with the facility's Nurse | | - | Requirement to document the of all staff involved in the | | |
| | Manager revealed | an area that contained two | | | and/or | | |
| | opened out to a sm | all common area that also the area was separated | | | treatment team physician | nd to | |
| | from a hallway that | led to common areas by a set ne Nurse Manager reported, | | | document that consultation is the date/time of the consult. | ncluding | |
| | during an interview | | | 1 | | | |

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/26/2011 FORM APPROVED OMB NO. 0938-039 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING_ С

04/08/2016

10L014

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

B. WING

| ANDY F | PROVIDER OR SUPPLIER PINES | 11 | REET ADDRESS, CITY, STATE, ZIP CODE 301 SE TEQUESTA TERRACE EQUESTA, FL. 33469 | |
|--------------------------|--|---------------------|--|---------------------------|
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (XS) COMPLETIO DATE |
| N 154 | Continued From page 17 | N 154 | N 154 Continued | : |
| | | | - Requirement for an MD or nurse to | ! |
| | [Documentation must include] the name of staff | | evaluate the well-being of the resident | |
| | involved in the emergency safety intervention. | 1 | immediately after the resident is | |
| | niversa in the entergency early and remova | | removed from and/or | |
| | | | and to document that | , |
| | This ELEMENT is not met as evidenced by: | | evaluation | |
| | Based on record review, observation and | | - Need to notify the resident's legal | ł |
| | interview, the facility failed to document in the | | guardian that the resident had a | 4 |
| | resident's records the names of the staff | | and/or and | į. |
| | members involved in a for 2 of 17 | , | document that notification | |
| | | ļ | - Requirement to conduct and | 1 |
| | | | document a face to face discussion | |
| | (Resident #16 and #17). | | with all staff and the resident involved | 1 |
| | | | in an emergency intervention. The | |
| | The findings included: | - | discussion must include the | |
| | | | circumstances resulting in the use of | |
| | Review on of the facility's own policies | | and/or and | |
| | and procedures titled, " and" | | strategies to be used by the staff, the | İ |
| | with the most recent review of revealed | | resident, or others that could prevent | |
| | that the policies and procedures documented a | | the future use of / | |
| | Registered Nurse (RN) to "complete the | | - Requirement to complete and | |
| | Justification for / packet on | | document a debriefing session within | |
| | each / episode by the end of the | | 24 hours after use of and/or | |
| | shift. Documentation must be completed within | | with the staff involved in the | |
| | the shift during which the intervention took place." | | emergency safety and/or | |
| | Review of the "Justification for | | and appropriate supervisory | } |
| | Restraint/Seclusion" sample document on | | and administrative staff to review the | |
| | revealed that the document required staff | | circumstances resulting in the use of | |
| | to document the names of the participants in the | | and/or and | |
| | Intervention. | | strategies to be used by the staff, the |] |
| | | | resident, or others that could prevent | |
| | Observations conducted on at | | further use of / If an | |
| | approximately 9:25 AM, with the facility's Nurse | | injury is sustained by a resident during | |
| | Manager revealed an area that contained two | | the use of and/or , | |
| | , with doors in place; the doors | | during the debriefing a plan to prevent |) |
| | opened out to a small common area that also | | further injury is to be developed and | |
| | contained a ; the area was separated | | documented in the medical record. | |
| | from a hallway that led to common areas by a set | | - Requirement to obtain and document | |
| | of double doors. The Nurse Manager reported, | | medical treatment promptly for any injury sustained by a resident during | |
| | during an interview, on at approximately | | the use of / | |

14:21:55 PRINTED: 04/26/201 VEI 39

| DEPARTMENT OF HEALTH | AND HUMAN SERVICES | · | FORM APPRO |
|------------------------------|-----------------------------|---------------------------------------|------------------|
| CENTERS FOR MEDICARE | & MEDICAID SERVICES | 0 | MB NO. 0938-0 |
| | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY |
| AND PLAN OF CORRECTION | IDENTIFICATION NUMBER: | A. SUILDING | COMPLETED |
| | | | C |
| | 10L014 | B. WING | 04/08/2016 |
| NAME OF PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| | | 11201 SE TECHIERTA TERRACE | |

| | | 10L014 | B. WING | · | | | C /08/2016 |
|--------------------------|---|--|--------------------|-----|---|--|--------------------------------------|
| NAME OF | PROVIDER OR SUPPLIER | lance and the same and | | 1 | TREET ADDRESS, CITY, STATE, ZIP CODE 1301 SE TEQUESTA TERRACE TEQUESTA, FL. 33469 | | 00/2010 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| N 154 | Continued From pa | ge 17 | N 1 | 154 | N 154 Continued The DON and RM reviewed and revis medical records forms related to documentation of the use of / | sed all | May 4, 201 |
| | involved in the eme | rgency safety intervention. | ! | | to ensure that all required elements co documented correctly and thoroughly. | uld be | |
| | Based on record re interview, the facility resident's records to members involved sampled residents | | | | justification for use of | staff, hip on: opriate and/or | 8, 2016 |
| | The findings include | led: | | | safety situation Revisions/clarifications to Restraint/Seclusion Policy Include | the ling: | |
| | | | | | Who may authorize the and/or Regulrement to obto physician's order for any and/or | aln a use of | \$; ; ; |
| | | episode by the end of the on must be completed within the intervention took place." | | | | face fent no | / : 1 : 1 : 1 : |
| | revealed th | " sample document on hat the document required staff ames of the participants in the | | | Requirement to fully do each use of Requirement to document | and/or | r I |
| | Manager revealed | AM, with the facility's Nurse an area that contained two | | | medical record, the en safety situation required/justified the and/or | nergency that | |
| | opened out to a sm | with doors in place; the doors hall common area that also | 1 | | interventions used, a outcome of the interventi | | į |

during an interview, on

contained a ; the area was separated from a hallway that led to common areas by a set

of double doors. The Nurse Manager reported,

and/or

Requirement to document the names of all staff involved in the

PRINTED: 04/28/2016

| | | AND HUMAN SERVICES | | | 0 | | APPROVED |
|--------------------------|----------------------------------|---|---------------------|-----|---|---------|-------------------------------------|
| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MU A. BUILI | | CONSTRUCTION | (X3) DA | D. 0938-039 TE SURVEY MPLETED |
| | | 10L014 | B. WING | | | 04 | C 1/08/2016 |
| NAME OF F | PROVIDER OR SUPPLIER | | | 51 | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| SANDY F | PINES | | | | 301 SE TEQUESTA TERRACE EQUESTA, FL 33468 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | COMPLETION DATE |
| N 154 | Continued From pe | ge 17 | N | 154 | N 154 Continued | | |
| | ID | and book about the common of staff | | | | | |

members involved in a The findings included:

1. Review on of the facility's own policies and procedures titled, " with the most recent review of that the policies and procedures documented a Registered Nurse (RN) to "complete the Justification for Restraint/Seclusion packet on . / episode by the end of the each shift. Documentation must be completed within the shift during which the intervention took place,"
Review of the "Justification for Restraint/ " sample document on

revealed that the document required staff

involved in the emergency safety intervention.

This ELEMENT is not met as evidenced by:

interview, the facility failed to document in the

sampled residents reviewed for seclusions and

for 2 of 17

Based on record review, observation and

(Resident #16 and #17).

resident's records the names of the staff

Observations conducted on approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set

of double doors. The Nurse Manager reported,

to document the names of the participants in the

Need to consult resident's treatment team physician for the and: and to document that consultation including the date/time of the consult. Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and to document and/or that evaluation Need to notify the resident's legal guardian that the resident had a : and/or document that notification · Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must

include the circumstances resulting in the use of and/or and strategles to be used by the staff, the resident, or others that could prevent the future use of/

during an interview, on

intervention.

at approximately

561-427-1576

2016 VEE 391

| DEPARTMENT OF HEALTH CENTERS FOR MEDICARE | | | FORM APPRO OMB NO. 0938-0 |
|---|---|--|-------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | (X3) DATE SURVEY COMPLETED |
| | 10L014 | B. WING | C 04/08/2016 |
| NAME OF PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CO | DE |
| SANDY PINES | | 11301 SE TEQUESTA TERRACE | |

| | | 10L014 | B. WING | | | 04/ | 08/2016 |
|---------|----------------------|---|---------|-----|---|---------------------|---------|
| AME OF | PROVIDER OR SUPPLIER | | | ST | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| A MIDS | Mire | | - 1 | 11 | 301 SE TEQUESTA TERRACE | | |
| ANDY F | JNF9 | | | TE | EQUESTA, FL 33469 | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | · ID | | PROVIDER'S PLAN OF CORRECTION | ON | ()(6) |
| PREFIX | (EACH DEFICIENC) | MUST BE PRECEDED BY FULL | PREFI | x ¹ | (EACH CORRECTIVE ACTION SHOUL | D BE | COMPLET |
| TAG | REGULATORY OR L | SC IDENTIFYING INFORMATION) | TAG | | CROSS-REFERENCED TO THE APPROI DEFICIENCY) | PRIATE | DATE |
| | | | <u></u> | _ | DEFICIENCE | | |
| | | | | - 1 | N 154 Continued | | |
| N 154 | Continued From pa | ge 17 | N 1 | 54 | Requirement to compl | | |
| | | | | į | Requirement to compi document a debriefing | | |
| | (Documentation mu | st include) the name of staff | 1 | 1 | within 24 hours after | | |
| | | rgency safety intervention. | ì | | and/or | with | 1 |
| | | | | | | in the | |
| | | | i | | emergency safety | and/or | |
| | This FLEMENT Is | not met as evidenced by: | 1 | | | and/or propriate | |
| | Based on record re | eview, observation and | Į | | supervisory and admir | | - |
| | | y falled to document in the | İ | | staff to review the circur | | |
| | | he names of the staff | : | | resulting in the use of | aincs | |
| | members involved | | | | and/or and 's | tratopies | |
| | | reviewed for seclusions and | | | to be used by the st | | |
| | | t #16 and #17). | | - 1 | resident, or others the | | |
| | (116810611 | in round mirj. | | | | se of | |
| | The findings include | led: | 1 | | | iniury is | |
| | THE MIGHINGS MICHAEL | idd. | | | sustained by a resident di | | |
| | 1. Review on | of the facility's own policies | | | use of and/or | | |
| | and procedures title | | 1 | 1 | during the debriefing a | plan to | |
| | with the most recei | | | | prevent further injury i | | |
| | | d procedures documented a | - | | developed and docume | nted in | |
| | | RN) to "complete the | | | the medical record. | | |
| | Justification for | / packet on | ÷ | | Requirement to obta | in and | |
| | each / | episode by the end of the | 1 | | document medical tr | eatment | |
| | | n must be completed within | | | promptly for any injury s | ustained | |
| | | ch the intervention took place." | | | by a resident during the | use of | |
| | Review of the "Jus | iffention for | 1 | | | | ! |
| | | n' sample document on | 1 | | | eclusion | |
| | | at the document on | ļ | | forms | | |
| | | mes of the participants in the | | | Documentation requirements | related | |
| | intervention. | ines of the bandopants in the | - | | to / | | |
| | intervention. | | 1 | - 1 | Expectations for full compliant | | |
| | Observations | untari an at | - | | / policy | and | |
| | Observations cond | | | | documentation requirements. | | |
| | approximately 9:25 | AM, with the facility's Nurse | | | | | |
| | ivianager revealed | an area that contained two ith doors in place; the doors | | | | | |
| | , V | nui appre in piace, ine doors | - | | | | |
| | | all common area that also | 1 | | | | |
| | contained a | ; the area was separated | ŧ | | | | |
| | from a nailway that | led to common areas by a set | | - 5 | | | |
| | | ne Nurse Manager reported, | | | | | |
| | during an interview | on at approximately | 1 | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

--1-2 PRINTED: 04/26/201

| E | & MEDICAID SERVICES | O | MB NO. 0938-03 |
|---|-----------------------|--|-------------------------------|
| | IDEATICICATION NUMBER | (X2) MULTIPLE CONSTRUCTION A. BUILDING | (X3) DATE SURVEY COMPLETED |
| | 10L014 | B. WING | C 04/08/2016 |

NAME OF PROVIDER OR SUPPLIER

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

STREET ADDRESS, CITY, STATE, ZIP CODE

| ANDY F | PINES | 1 | 11301 SE TEQUESTA TERRACE TEQUESTA, FL 33489 | | |
|--------------------------|---|--------------------|--|---|-------------------|
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFI TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | COMPLETIO DATE |
| N 154 | Continued From page 17 | N 1 | 54 | N 154 Continued | |
| | [Documentation must include] the name of staff involved in the emergency safety intervention. | | | Competency was assessed via post-tests maintained in individual employee's HR file. Each | : |
| | This ELEMENT is not met as evidenced by. Based on record review, observation and interview, the facility failed to document in the resident's records the names of the staff members involved in a sampled residents reviewed for and (Resident #16 and #17). The findings included: | | | employee taking the training was also required to sign an attestation of his/her understanding, of the expectations for compliance with complete statistic policy and documentation requirements. Nurses were additionally required to complete a correctly completed set of documents to verify understanding of the documentation requirements. Any employee failing to complete training by , 2016 will be required to complete the training before being allowed to return to work. | |
| | Review on of the facility's own policies and procedures titled, " and " with the most recent review of revealed that the policies and procedures documented a Registered Nurse (RN) to "complete the leading to the sec | | | | |
| | Justification for Restraint/Seclusion packet on each seclusion/ episode by the end of the shiff. Documentation must be completed within the shift during which the intervention took place." Review of the "Justification for " sample document on | | | • • • • • • • • • • • • • • • • • • • | |
| | i revealed that the document required staff to document the names of the participants in the intervention. | | | | |
| | Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two with doors in place; the doors | | | | |
| | opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an Interview, on at approximately | | | | |

04/08/2016

14:23:18 PMINTED: 04/26/2016 FORM APPROVEC OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A BUILDING _

10L014

NAME OF PROVIDER OR SUPPLIER

B. WING STREET ADDRESS, CITY, STATE, ZIP CODE

SANDY DINES

11301 SE TEQUESTA TERRACE

| ANDY F | DY PINES | | TEQUESTA, FL 33469 | |
|--------------------------|--|---------------------|--|--------------------|
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | COMPLETION DATE |
| | | | N 154 Continued | 1 |
| N 154 | Continued From page 18 | N 154 | | |
| | 9:25 AM that the facility had taken off the doors to | | Monitoring: | and ongo |
| | re-added them after a revision of their policies. | | The DON/designees and/or the 100% | and ongo |
| | Review on of the facility's own video | | of all documents related to the use of | 4 |
| | recording revealed Residents #16 and #17 on | | / on a daily basis to ensure | |
| | at approximately 5:00 PM, locked away | | compliance with documentation standards and | 4 |
| | from other residents, in an area that they did not | | policy expectations. Aggregated results of the | |
| | frequent as part of their dally routines. The | | monitoring is reported monthly by the Director | ; |
| | residents were observed in the area that | | of Nursing to the facility PI Committee and | , |
| | contained the two small , without doors at | | quarterly to the Governing Body. Any non- compliance is addressed through retraining | |
| | that time, leading into a common area that had a | | compliance is addressed through retraining | |
| | set of locked double doors. The area was void of | | and/or disciplinary action as appropriate. | ŧ. |
| | any furniture, except for a plastic chair. There | | For a period of four months, the DON and | |
| | was a staff member present in the area. The | | are conducting daily random audits via | |
| | were observed kicking the double | | surveillance camera of each residential unit's | |
| | doors; the doors did not open when kicked. They | | area with each area viewed at least 2 | Ì |
| | were observed pacing back and forth in the area | | time periods each shift. Any incident of | |
| | and this lasted at least 5 minutes. | | observed or is compared with | |
| | Review of Resident #16's record on | | documented/ to ensure that | |
| | revealed evidence of documentation that the | | all episodes are correctly documented. | 1 |
| | resident was admitted to the facility on | | Aggregated results of the monitoring is reported | 1 |
| | The resident's record revealed evidence of | | monthly by the Director of Nursing to the facility | ì |
| | documentation that the facility sent the resident to | | PI Committee and quarterly to the Governing | |
| | a receiving facility on | | Body. Any non-compliance is addressed through | ì |
| | accompanied by Law Enforcement officers after | | retraining and/or disciplinary action as | 1 |
| | the resident disrupted the unit, instigated peers | | appropriate. When compliance is maintained for | |
| | and was not responding to redirection and the | | four months, the monitored will be decreased to | ': |
| | facility discharged the resident at that time. | | a sample of each shift weekly. | 1 |
| | Further review of the resident's record revealed | | | |
| | no evidence of documentation that staff | | Responsible: | |
| | documented the intervention in the resident's record to include the names of the staff | | Director of Nursing | |
| | members involved in the | | Dilector of Marshig | |
| | 2. Review of Resident #17's record on | | | |
| | revealed that the resident was admitted to the | | | |
| | facility on . The resident's record | | | 1 |
| | documented that the facility sent the resident to a | | | 1 |

receiving facility on

| 1-427-1576 DEPARTMENT OF HEALTH CENTERS FOR MEDICARE | | 14:23:41 | PRINTED: 04/26/2016 FORM APPROVEE OMB NO. 0938-0391 |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | (X3) DATE SURVEY COMPLETED |
| | | | \ C |
| | 10L014 | B. WING | 04/08/2016 |
| | | | |

STREET ADDRESS, CITY, STATE, ZIP CODE

| SANDY PINES | | | 11301 SE TEQUESTA TERRACE TEQUESTA, FL. 33469 | | |
|--------------------------|---|---------------------|--|----------------------------|--|
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X8) COMPLETION DATE | |
| N 154 | | | CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | , 2016 | |
| | emergency safety situation, the interventions used, and their outcomes This ELEMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to document in the residents records that the resident had an emergency safety situation the resident had an emergency safety situation the resident facility interventions used and the outcome for 2 of 17 sampled residents reviewed for seclusions and (Resident #16 and #17). The findings included: Review on of the facility's own policies and procedures titled, "and with the most recent review of revealed that the policies and procedures documented a | | to ensure that are required elements are included and clearly stated for staff interpretation. Key elements of the policy include: Clarification on the definition of and Who may authorize the use of and/or Requirement to obtain a physician's order for any use of and/or Requirement to conduct and document a face to face assessment of the resident no later than one hour after the initiation of the and/or Requirement to fully document each use of and/or Requirement to trilly document each use of and/or | 2000 2001 20 | |

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PRINTED: 04/26/2016 FORM APPROVED

04/08/2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING . B. WING

(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED С

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE

SANDY PINES TEQUESTA, FL 33469 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION 1D (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG DEFICIENCY) N 155 Continued N 155 Continued From page 20 N 155 Requirement to document in the Registered Nurse (RN) to "complete the medical record, the emergency safety Justification for packet on situation that required/justified the episode by the end of the each and/or use of , the shift. Documentation must be completed within interventions used, and the outcome the shift during which the intervention took place." of the intervention Review of the "Justification for Requirement to document the names /Seclusion" sample document on of all staff involved in the revealed that the document required staff and/or and its outcome. to document the Need to consult with the resident's treatment team physician for the . and to and Observations conducted on approximately 9:25 AM, with the facility's Nurse document that consultation including the date/time of the consult. Manager revealed an area that contained two - Requirement for an MD or nurse to , with doors in place; the doors opened out to a small common area that also evaluate the well-being of the resident immediately after the resident is contained a ; the area was separated and/or removed from from a hallway that led to common areas by a set and to document that of double doors. The Nurse Manager reported, **pysluation** during an interview, on at approximately Need to notify the resident's legal 9:25 AM that the facility had taken off the doors to guardian that the resident had a to avoid . but and/or re-added them after a revision of their policies. document that notification of the facility's own video Review on Requirement to conduct and recording revealed Residents #16 and #17 on document a face to face discussion at approximately 5:00 PM, locked away with all staff and the resident involved from other residents, in an area that they did not in an emergency intervention. The frequent as part of their daily routines. The discussion must include the residents were observed in the area that circumstances resulting in the use of , without doors at contained the two small and/or and that time, leading into a common area that had a strategies to be used by the staff, the set of locked double doors. The area was void of resident, or others that could prevent any furniture, except for a plastic chair. There the future use of was a staff member present in the area. The residents were observed kicking the double

doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes. Review of Resident #16's record on

PRINTED: 04/26/201

561-427-1576 STONE OF REALITH AND HUMAN SERVICES FORM APPROVE CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED STATEMENT OF DESIGNATION (XZ) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION A RUII DING C 10L014 R WING 04/08/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE SANDY PINES TEQUESTA, FL 33469 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT in (X5) MPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY N 155 N 155 Continued N 155 Continued From page 20

Registered Nurse (RN) to "complete the

Justification for Restraint/ packet on each 1 episode by the end of the shift. Locumentation must be completed within the shift during which the intervention took place." Review of the "Justification for Restraint/ " sample document on revealed that the document required staff

and its outcome

Observations conducted on approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a the area was separated from a hallway that led to common areas by a set

of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to to avoid , but the re-added them after a revision of their policies. Review on of the facility's own video

recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away nom owner residents, in an area that they did not frequent as part of their dally routines. The residents were observed in the area that , without doors at contained the two smallthat time, leading into a common area that had a set of locked double doors. The area was vold of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes. Review of Resident #16's record on

revealed evidence of documentation that the

Requirement to document a debriefing session within 24 hours after use of and/or with the staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent further use of + Injury is sustained by a resident during the use of and/or during the debriefing a plan to prevent further injury is to be developed and documented in the medical record. Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of . 2016

and revised all The DON and medical records forms related to the documentation of the use of to ensure that all required elements could be documented correctly and thoroughly.

, 2016 , and designees, along with The DON. Corporate Divisional Clinical Directors, provided retraining to all nurses, direct care staff. attending psychiatrists, and senior leadership on: Definition of and appropriate justification for use of during for an emergency

safety situation

to accument the

561-427-1576

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| CENTERS FOR MEDICARE | | | FORM APPR OMB NO. 0938 |
|---|---|--|-----------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | (X3) DATE SURV COMPLETED |
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| | 10L014 | B. WING | 04/08/20 |
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| 10L014 B. WING | TREET ADDRESS, CITY, STATE, ZIP CODE | 04/08/2016 |
|--|--|--|
| CANDY DINEC | 1391 SE TEQUESTA TERRACE TEQUESTA, FL. 33469 | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLETION |
| N 155 Continued From page 20 Registered Nurse (RN) to "complete the Justification for Seclusion packet on each / splaced by the end of the shift. Documentation must be completed within the shift during which the intervention took place." Review of the "Justification for Restraint/Seclusion" sample document on revealed that the document required staff to document the and its outcome. Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two with doors in place; the doors opened out to a small common area that also contained a "the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to the cade of the shall was a separated from a contained a "the area will be doors to the second of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:09 M, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that a set of locked double doors. The rarea was void of any furniture, except for a plastic chair. There was a steff member present in the area. The residents were observed led not prove hoserved lecked. They were observed besteryed bestery besteryed possers area. | Revisions/clarifications / Policy Inclu Who may authorize the and/or Requirement to obb physician's order for any and/or Requirement to conduct document a face to assessment of the resid later than one hour af initiation of the Requirement to documen Requirement to documen medical record, the em safety situation required/justfilled the to and/or interventions used, an outcome of the intervention Requirement to documen manes of all staff involve and/or Need to consult will resident's treatment | use of use of use of and face ent no and/or current and/or t in the ergency that that the in the than not the team and and the that the team and the team and and the team and and and and the team and and and and the team and and and the team and and and and the team and and and the team and and and the team and and the team and the team and the team and the team and the team and the team and the team and the team and the team and the team and the team the the team the the team the the team the team the the team the the team the the team the the team the the team the the the the the the the th |

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04/08/2016

(X5) APLETION DATE

| CENTERS FOR MEDICARE | | | RINTED: 04/26/20 FORM APPROVE MB NO. 0938-039 |
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| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION A. BUILDING | (X3) DATE SURVEY |
| AND PLAN OF CORRECTION | IDENTIFICATION NUMBER: | | COMPLETED |

B. WING

NAME OF PROVIDER OR SUPPLIER

SANDY PINES (X4) ID

TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL

10L014

STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG

N 155 Continued

N 155 Continued From page 20 Registered Nurse (RN) to "complete the

Justification for packet on /restraint episode by the end of the shift. Documentation must be completed within the shift during which the intervention took place."

REGULATORY OR LSC IDENTIFYING INFORMATIONS

Review of the "Justification for /Seclusion" sample document on revealed that the document required staff and its outcome. to document the

Observations conducted on approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also : the area was separated contained a

from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to to avoid seclusions, but re-added them after a revision of their policies. Review on of the facility's own video recording revealed Residents #16 and #17 on

at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The

residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes. Review of Resident #16's record on

developed and documented in

Facility ID: RC57000060P

N 155 Need to notify the resident's legal guardian that the resident had a and/or and

future use of

DEFICIENCY)

document that notification Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must Include the circumstances resulting in the use of and/or and strategles to be used by the staff, the resident, or others that could prevent the

Requirement to complete and

document a debriefing session within 24 hours after use of and/or with the staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and 'strategies to be used by the staff, the resident, or others that could further prevent 1150 Ωf restraint/seclusion. If an injury is sustained by a resident during the use of and/or during the debriefing a plan to prevent further injury is to be

the medical record. Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of

1.

from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to to avoid seclusions, but re-added them after a revision of their policies. of the facility's own video Review on recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their dally routines. The residents were observed in the area that , without doors at contained the two small that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There

was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lested at least 5 minutes. Review of Resident #16's record on revealed evidence of documentation that the

Facility ID: RC57000080P

of documents to verify understanding of the

documentation requirements. Any employee

be required to complete the training before

failing to complete training by

being allowed to return to work.

, 2016 will

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

55 PRINTED: 04/26/201€

FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY COMPLETED

04/08/2016

NAME OF PROVIDER OR SUPPLIER

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

10L014

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

. WING

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE

SANDY PINES TEQUESTA, FL 33469 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 155 Continued From page 21 N 155 N 155 Continued resident was admitted to the facility on , 2016 The resident's record revealed evidence of Monitoring: documentation that the facility sent the resident to and ongoins receiving facility on 100% The DON/designees and/or the of all documents related to the use of accompanied by Law Enforcement officers after on a daily basis to ensure the resident disrupted the unit, instigated peers -1 compliance with documentation standards and and was not responding to redirection and the policy expectations. Aggregated results of the facility discharged the resident at that time. monitoring is reported monthly by the Director Further review of the resident's record revealed of Nursing to the facility PI Committee and no evidence of documentation that staff quarterly to the Governing Body. Any nondocumented the emergency safety situation compliance is addressed through retraining , in the resident's record to include the and/or disciplinary action as appropriate. interventions used and the outcome. For a period of four months, the DON and conducting dally random audits via surveillance camera of each residential unit's 2. Review of Resident #17's record on revealed that the resident was admitted to the area with each area viewed at least 2 . The resident's record facility on time periods each shift. Any incident of observed documented that the facility sent the resident to a is compared with , , , or receiving facility on to ensure that documented/ accompanied by Law Enforcement officers after all episodes are correctly documented. the resident disrupted the unit, instigated peers Aggregated results of the monitoring is reported and was not responding to redirection. The monthly by the Director of Nursing to the facility resident's record revealed evidence of PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through documentation that the facility re-admitted the and discharged the resident retraining and/or disciplinary action as resident on appropriate. When compliance is maintained for , Further review of the resident's ดก four months, the monitored will be decreased to record revealed no evidence of documentation that staff documented the emergency safety a sample of each shift weekly. in the resident's record to situation include the interventions used and the outcome. at 12:03 PM In an interview conducted on Director of Nursing with the facility's Risk Manager, the Risk Manager reported that the facility was a locked facility, the units were also locked and she inquired whether

N 160 : 483,360 CONSULTATION WITH TREATMENT

this was a

N 160

14:27:05 561-427-1576 PRINTED: 04/26/2019 FORM APPROVE DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING ___

10L014

8. WING _____

04/08/2016

| NAME OF PROVIDER OR SUPPLIER | | 7 | STREET ADDRESS, CITY, STATE, ZIP CODE | |
|------------------------------|---|---------------------|---|--|
| SANDY | , | 1 | 11301 SE TEQUESTA TERRACE | |
| SANDY | INES | | TEQUESTA, FL 33469 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| PRÉFIX TAG | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | |
| | revealed that the most recent review of the policies and procedures documented a Registered Nurse (RN) to "complete the Justification for packet on each place of the shift. Documentation must be completed within the shift during which the intervention took place." (Secusion" sample document on Secusion" sample document on | | of all staff involved in the and/or Need to consult with the resident's treatment team physician for the and and to document that consultation including the date/time of the consult. | to the state of th |

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

14:27:27

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

PRINTED: 04/26/2016 FORM APPROVED OMB NO. 0938-0391

04/08/2016

(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING ___ С

10L014

B: WING

| NAME OF PROVIDER OR SUPPLIER | | T | 57 | REET ADDRESS, CITY, STATE, ZIP CODE | |
|------------------------------|--|---------------------|-----|--|----------------------------|
| | | | 11 | 301 SE TEQUESTA TERRACE | |
| SANDY | INES | | TI | EQUESTA, FL 33469 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (XS) COMPLETION DATE |
| N 160 | Continued From page 23 | N 10 | 60 | N 160 Continued | |
| I | revealed that the document required staff | | | Requirement for an MD or nurse to | |
| | to record the date and time the resident's primary | | - 1 | evaluate the well-being of the resident | |
| | physician was notified. | | | immediately after the resident is | |
| | Observations conducted on at | | | removed from and/or | |
| | approximately 9:25 AM, with the facility's Nurse | | | and to document that | |
| | Manager revealed an area that contained two | | | evaluation - Need to notify the resident's legal: | |
| | , with doors in place; the doors | | i | guardian that the resident had a | ! |
| | opened out to a small common area that also | | | and/or and | |
| | contained a ; the area was separated | | | document that notification | |
| | from a hallway that led to common areas by a set | | 9 | - Requirement to conduct and | |
| | of double doors. The Nurse Manager reported, | | | document a face to face discussion | |
| | during an interview, on at approximately | | i i | with all staff and the resident involved | i |
| | 9:25 AM that the facility had taken off the doors to | | , | in an emergency intervention. The | |
| | the to avoid but | | | discussion must include the | |
| | re-added them after a revision of their policies. | | | circumstances resulting in the use of | - |
| | Review on of the facility's own video | | | and/or and | |
| | recording revealed Residents #16 and #17 on | | | strategies to be used by the staff, the | |
| | at approximately 5:00 PM, locked away | | | resident, or others that could prevent | |
| | from other residents, in an area that they did not | | | the future use of | |
| | frequent as part of their dally routines. The | | | Requirement to complete and document a debriefing session within | 1 |
| | residents were observed in the area that contained the two small without doors at | | | 24 hours after use of and/or | 1 |
| | that time, leading into a common area that had a | | | with the staff involved in the | |
| | set of locked double doors. The area was void of | | | emergency safety and/or | |
| | any furniture, except for a plastic chair. There | | | and appropriate supervisory | |
| | was a staff member present in the area. The | | | and administrative staff to review the | |
| | residents were observed kicking the double | | - | circumstances resulting in the use of | ř. |
| | doors; the doors did not open when kicked. They | | | and/or and | |
| | were observed pacing back and forth in the area | | | strategies to be used by the staff, the | : |
| | and this lasted at least 5 minutes. | | - | resident, or others that could prevent | i |
| | Review of Resident #16's record on | | - 3 | further use of restraint/seclusion. If an | 1 |
| | revealed evidence of documentation that the | | | injury is sustained by a resident during | |
| | resident was admitted to the facility on | | | the use ofand/or . | |
| 1 | The resident's record revealed evidence of | | | during the debriefing a plan to prevent further injury is to be developed and | |
| | documentation that the facility sent the resident to | | | further injury is to be developed and documented in the medical record. | |
| 1 | a receiving facility on | | | - Requirement to obtain and document | |
| | accompanied by Law Enforcement officers after | | | medical treatment promptly for any | |
| i | the resident disrupted the unit, instigated peers | | | injury sustained by a resident during | |
| | the resident disrupted the drift, motigated poors | | | injury sustained by a resident during | |

and was not responding to redirection and the

Corporate Divisional Clinical Directors, provided

Definition of and appropriate

during for an emergency

/Sectusion Policy including:

physician's order for any use of

document a face to face

assessment of the resident no

later than one hour after the

Requirement to fully document

· Requirement to document in the

and/or

outcome of the intervention

and/or

medical record, the emergency

required/justifled the use of

interventions used, and the

Requirement to document the

names of all staff involved in the

situation

. Who may authorize the use of

Requirement to obtain a

and/or

and/or

Requirement to conduct

Initiation of the

each use of

safety

and/or

and/or

and/or

., the

retraining to all nurses, direct care staff,

attending psychiatrists, and senior leadership on:

justification for use of

Revisions/clarifications

safety situation

PRINTED: 04/26/2016 FI 19

| CENTE | RS FOR MEDICARE | & MEDICAID SERVICES | | ON | | 0938-039 |
|---|---|--|---|--|-------------------------------|----------------------------|
| TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
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| NAME OF I | PROVIDER OR SUPPLIER PINES | | 1 | STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE . | (X5) COMPLETION DATE |
| | to record the date a physician was notifi Observations cond approximately 9:25 Manager revealed | nat the document required staff and time the resident's primary led. | N 160 | The DON and and revision medical records forms related to | the dusion ald be | , 2016 |

contained a the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to to avoid seclusions, but re-added them after a revision of their policies. of the facility's own video Review on recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away

from other residents, in an area that they did not

frequent as part of their daily routines. The

opened out to a small common area that also

residents were observed in the area that , without doors at contained the two small that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes. Review of Resident #16's record on revealed evidence of documentation that the resident was admitted to the facility on The resident's record revealed evidence of documentation that the facility sent the resident to

and was not responding to redirection and the *ORM CMS-2587(02-99) Previous Versions Obsolete

receiving facility on

accompanied by Law Enforcement officers after

the resident disrupted the unit, instigated peers

Fecility ID: RC57000080P

If continuation sheet Page 24 of 48

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FORM APPROVE OMB NO. 0938-039 IRVE

|) MULTIPLE CONSTRUCTION | (X3) DATE SU COMPLE |
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04/08/2016

STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE

NAME OF PROVIDER OR SUPPLIER

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

SANDY PINES

(X4) ID PREFIX

TAG

TEQUESTA, FL 33469 ID PREFIX

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (XS) MPLETION DATE DEFICIENCY)

N 160 Continued From page 23

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SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that , without doors at contained the two small that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes. Review of Resident #16's record on revealed evidence of documentation that the resident was admitted to the facility on The resident's record revealed evidence of documentation that the facility sent the resident to

receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers

N 160 Continued

- N 160
- Need to consult with the team resident's treatment physician for the and and to document that consultation including the date/time of the consult.
 - Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and to document and/or that evaluation
 - Need to notify the resident's legal guardian that the resident had a .. and and/or _. document that notification
- Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must circumstances include the resulting in the use of and strategies to and/or be used by the staff, the resident, or others that could prevent the future use of

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| 27-1576 PARTMENT OF HEALTH CENTERS FOR MEDICARE | AND HUMAN SERVICES | | PRINTED: 04/26/ FORM APPRO OMB NO. 0938- |
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Review on

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SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG

m TAG

TEQUESTA, FL 33469 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

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N 160 Continued From page 23

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re-added them after a revision of their policies.

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receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection and the

N 160 N 160 Continued

document a debriefing session within 24 hours after use of and/or with the staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and 'strategies to be used by the staff, the resident, or others that could prevent further restraint/ use of . If an injury is sustained by a resident during the use of and/or during the debriefing a plan to prevent further injury is to be developed and documented in

Requirement to complete and

- the medical record. · Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of /seclusion
- Revisions to the Restraint/ forms
- Documentation requirements related to 1
- Expectations for full compliance to the policy documentation requirements.

Facility ID: RC57000060F

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| | | AND HUMAN SERVICES | | · · | | 04/26/20 |
| | | & MEDICAID SERVICES | | , | | APPROVE 0938-03 |
| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUI A. BUILL | TIPLE CONSTRUCTION | (X3) DAT | E SURVEY PLETED |
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| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| SANDY F | PINES | | | 11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469 | | |
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| N 160 | Continued From pa | ge 23 | N · | N 160 Continued | | |
| | to record the date a physician was notif Observations cond approximately 9:25 Manager revealed working and approximately 9:25 Manager revealed from a hallway that of double doors. The during an interview 9:25 AM that the father e-added them after Review on recording revealed frequent as part of residents were obscontained the two stat time, leading in set of locked double any furniture, excey was a staff membe versidents were observed as a staff membe residents were observed. | ucted on at AM, with the facility's Nurse an area that contained two fith doors in place, the doors all common area that also ; the area was separated led to common areas by a set to Nurse Manager reported, on at approximately cility had taken off the doors to to avoid sectusions, but a revision of their policles of the facility's own video Residents #16 and #17 on nately 5:00 PM, locked away s, in an area that they did not their daily routines. The erved in the area that | | requirements. Nurses were ad required to complete a correctly comp of documents to verify understandin documentation regulrements. Any | file. Each required rstanding ce with nentation iditionally deted set g of the employee 2016 will | |

were observed pacing back and forth in the area and this lasted at least 5 minutes. Review of Resident #16's record on revealed evidence of documentation that the resident was admitted to the facility on The resident's record revealed evidence of documentation that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers

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| CENTERS FOR MEDICARE | & MEDICAID SERVICES | 0 | MB NO. 0938- |
| TATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | (X3) DATE SURVE COMPLETED |
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| NAME OF PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE | |

SANDY PINES

11301 SE TEQUESTA TERRACE

TEQUESTA, FL 33469 SUMMARY STATEMENT OF DESICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG N 160 Continued N 160 Continued From page 24 N 160 Monitoring: facility discharged the resident at that time. 2016 Further review of the resident's record revealed 100% and ongoing The DON/designees and/or the I no evidence of documentation that staff of all documents related to the use of documented the () Intervention in the on a daily basis to ensure resident's record, including evidence of consulting compliance with documentation standards and with the resident's treatment team physician for policy expectations. Aggregated results of the the use of a monitoring is reported monthly by the Director of Nursing to the facility Pi Committee and quarterly to the Governing Body. Any non-2. Review of Resident #17's record on compliance is addressed through retraining revealed that the resident was admitted to the and/or disciplinary action as appropriate. facility on . The resident's record documented that the facility sent the resident to a For a period of four months, the DON and receiving facility on conducting daily random audits via surveillance camera of each residential unit's accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers area with each area viewed at least 2 and was not responding to redirection. The time periods each shift. Any incident of resident's record revealed evidence of is compared with or observed documentation that the facility re-admitted the to ensure that documented and discharged the resident all episodes are correctly documented. resident on . Further review of the resident's Aggregated results of the monitoring is reported record revealed no evidence of documentation monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing ...) intervention that staff documented the (Body. Any non-compliance is addressed through in the resident's record, including evidence of retraining and/or disciplinary action as consulting with the resident's treatment team appropriate. When compliance is maintained for physician for the use of a four months, the monitored will be decreased to at 12:03 PM in an interview conducted on a sample of each shift weekly. with the facility's Risk Manager, the Risk Manager reported that the facility was a locked facility; the Responsible: units were also locked and she inquired whether this was a N 161 Director of Nursing N 161 483.360(b) CONSULTATION WITH TREATMENT TEAM PHYSICIAN The person ordering the use of or must-483,360(b) Document in the resident's record the

14:29:41 ...-. -.. PRINTED: 04/26/2016 FORM APPROVED

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA

(X2) MULTIPLE CONSTRUCTION A. BUILDING __

OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED С

10L014 NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

| SANDY F | PINES | | 11301 SE TEQUESTA TERRACE TEQUESTA, FL. 33469 | | | |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (XS) COMPLETION DATE | | |
| N 161 | Continued From page 25 | N 16 | 1 | | | |
| | date and time the team physician was consulted. | 11 10 | Corrective Actions: | , 2016 | | |
| | This ELEMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to document, in the resident's record, the date and time the team physician was consulted for the use of a for 2 of 17 sampled residents reviewed for seclusions and #17). The findings included: Review on of the facility's own policies and procedures tilled, " and with the most recent review of revealed that the policies and procedures documented a Registered Nurse (RN) to "complete the Justification for 'seclusion packet on each / episode by the end of the shift. Documentation must be completed within the shift during which the intervention took place." Review of the "Justification for / sample document on revealed that the document required staff to record the date and time the team physician was notified. Observations conducted on | | The Director Nursing (DON) and facility Risk Manager () reviewed and revised the facility policy related to the use and documentation of and and and and and and and and and and | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | |
| | approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also | | Requirement to document the names of all staff involved in the and/or | | | |
| | operate dut to a sime common ace area asso- contained at the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an Interview, on at approximately 9:25 AM that the facility had taken off the doors to the to avoid sec | ! | Need to consult with the resulents treatment team physician for the and and to document that consultation including the date/time of the consult. | | | |

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| ANDY I | rines | | i i | 7 | EQUESTA, FL 33469 | | |
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| N 161 | Continued From page | | N 1 | 61 | N 161 Continued | | |
| | | the facility's own video | | | - Requirement for an MD or r | urse to | |
| | | esidents #16 and #17 on | | | evaluate the well-being of the | resident | |
| | | tely 5:00 PM, locked away | | | Immediately after the res | | |
| | | in an area that they did not | | | removed from | and/or | |
| | frequent as part of the | oir daily routines. The | | | and to docume | nt that | |
| | residents were observ | ed in the area that | | | evaluation | | i |
| | contained the two sm | | | | Need to notify the residen | ts legal | |
| | that time, leading into | a common area that had a | 1 | | guardian that the resident | nad a | |
| | set of locked double of | loors. The area was vold of | | | and/or | and | |
| | any furniture, except | for a plastic chair. There | | | document that notification | t and | į. |
| | was a staff member p | resent in the area. The | | | | | 1 |
| | residents were obser | ved kicking the double | i | | document a face to face d with all staff and the resident | lavelyed | è |
| | doors: the doors did r | not open when kicked. They | 1 | | with all starr and the resident | on. The | |
| | | back and forth in the area | | | in an emergency intervention discussion must include | | i |
| | and this lasted at leas | | 1 | | discussion must includ circumstances resulting in the | | |
| | Review of Resident # | | i | | circumstances resulting in u | e use of | 1 |
| | revealed avidence of | documentation that the | 1 | | strategies to be used by the | | |
| | resident was admitted | | | | resident, or others that could | nrovent | |
| | | revealed evidence of | | | the future use of | proven | |
| | | e facility sent the resident to | F. | | - Requirement to comple | te and | |
| | | facility on | | | document a debriefing session | on within | |
| | | Enforcement officers after | 1 | | 24 hours after use of | and/or | |
| | | the unit, instigated peers | 1 | | with the staff involve | ed in the | 1 |
| | | ng to redirection and the | | | emergency safety | and/or | 1 |
| | | resident at that time. | 1 | | and appropriate st | pervisory | ļ |
| | | resident's record revealed | 1 | | and administrative staff to n | evlew the | |
| | no evidence that staff | | | | circumstances resulting in ti | ne use of | |
| | | on in the resident's record, | | | and/or | | |
| | | cumented the date and time | i | | strategies to be used by the | staff, the | |
| | | as consulted for the use of a | į. | | resident, or others that coul | d prevent | 1 - |
| | intervention | | 1 | | further use of / | lf an | |
| | , migor verillo | • | | | injury is sustained by a resid | ent during | |
| | | | 1 | | the use of and/or | | |
| | 2. Review of Residen | #17's record on | Į. | | during the debriefing a plan | o prevent | |
| | | dent was admitted to the | 1 | | further injury is to be deve | oped and | |
| | | he resident's record | 1 | | documented in the medical r | ecord. | |
| | | facility sent the resident to a | | | - Requirement to obtain and | uocument | |
| | receiving fa | | 1 | | medical treatment prompti | y ior dhy | |
| | accompanied by I aw | Enforcement officers after | | | | anc oursig | |
| | , accompanied by Law | colete Event ID: TISR11 | | | the use of / | | Page 27 |

PRINTED: 04/26/2016 FORM APPROVED OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

A. BUILDING_

10L014 B. WING

С 04/08/2016

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

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| N 161 | Conlinued From page 26 Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5.00 PM. looked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that contained the two small without doors at that time, leading into a common area that had a set of looked double doors. The area was void of any furniture, except for a pastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes. Review of Resident #16's record on revealed evidence of documentation that the resident was admitted to the facility on The resident's record revealed evidence of documentation that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection and the facility discharged the resident at that time. Further review of the resident's record revealed no evidence that staff documented the (Intervention.) | N 1 | N 161 Continued | | | |
| | Review of Resident #17's record on revealed that the resident was admitted to the facility on . The resident's record documented that the facility sent the resident to a receiving facility on accommanied by Law Enforcement officers after | | required/justified the use of and/or , the interventions used, and the outcome of the intervention • Requirement to document the names of all staff involved in the and/or | | | |

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| | | AND HUMAN SERVICES | | | | | FORM / | APPROVE |
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| N 161 | Continued From pa | ge 26 | N 1 | D4 | | ment wit | h the | |
| | Review on | of the facility's own video | | | | | | |
| | | | | | | | and | |
| | at approxin | nately 5:00 PM, locked away | | | | | nt that: | |
| | | | | | consultation | including | the | |
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| | contained the two s | | : | | | | | |
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| | residents were observed kicking the double | | | | | the residen | r's legal : | |
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| | and this lasted at le | | | | | | | |
| | Review of Resident | #16's record on | | | | | | |
| | revealed evidence | of documentation that the | | | | | | |
| | resident was admitted to the facility on The resident's record revealed evidence of | | | | | | | |
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| | a receivi | ng facility on | | | | | | |
| | accompanied by La | w Enforcement officers after | | | | | egies to | |
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| | the team physician | was consulted for the use of a | 14 | | | | | |
| | Intervent | | | | | | | |
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| | documented that the facility sent the resident to a | | | | | | | |
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| | | | | Castle, In. DOCTORNOO | | If continued | on cheet C | nna 27 of 4 |
| ORM CMS-2 | 567(02-99) Previous Versions | IDENTIFICATION NUMBER: 10 10 14 B. WINS STREET ADDRESS, CITY, STATE, ZIP CODE 11 20 1 SE TEQUESTA, FL. 33469 STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY PULL PRESY PROVIDERS THAN OF CORRECTION IN 12 1 CONTINUE A PRECEDED BY PULL PRESY PROVIDERS THAN OF CORRECTION IN 12 1 CONTINUE A PRECEDED BY PULL PRESY PROVIDERS THAN OF CORRECTION IN 12 1 CONTINUE A PRECEDED BY PULL PRESY PROVIDERS THAN OF CORRECTION IN 12 1 CONTINUE A PRECEDED BY PULL PRESY PROVIDERS THAN OF CORRECTION IN 13 1 CONTINUE A PRECEDED BY PULL IN 14 1 Need to consult with the resident's treatment team physician for the and comment that the observed in the area that the observed in the area that the observed in the area that the observed in the area that the comment of the consult. There are was void of known from the preceded that the facility of an observed kicking the double so did not open when kicked. There are all least 5 minutes. In page 26 In page 26 In 12 1 PRESY PROVIDER'S PLAN OF CORRECTION IN 161 Continued In Page 26 In 16 1 Need to consult with the resident of the consult. The team of the resident in the area and the consult and the consult and the consult and the consult and the consult and the consult and the consult and the consult and the resident in mediately after the resident form and of and to document that consultation and the resident that the resident to add and/or and to document that evaluation and/or and to document that evaluation and/or and to document that evaluation and/or and to document that evaluation and/or and to document that evaluation and/or and to document that evaluation and/or and to document that the resident in the and/or and to document that the resident in the and and/or and to document that the resident in the and/or and to document that the resident in the and/or and to document that the resident in the and/or and to document that the resident in the and/or and to document that the resident in the and/or and document and/or and to document that the resident in the and/or a | | | | | | |
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PRINTED: 04/26/201 FORM APPROVED OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DESIGNOUS

10L014

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: DIND BUR A

(X2) MULTIPLE CONSTRUCTION

04/08/2016

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE

SANDY PINES TEQUESTA, FL 33469 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID PREFIX TAG (D (X5) COMPLETION DATE TAG DEFICIENCY) N 161 Continued N 161

N 161 Continued From page 26

of the facility's own video Review on recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes. Review of Resident #16's record on revealed evidence of documentation that the resident was admitted to the facility on The resident's record revealed evidence of documentation that the facility sent the resident to receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection and the facility discharged the resident at that time. Further review of the resident's record revealed no evidence that staff documented the

) intervention in the resident's record, including that staff documented the date and time the team physician was consulted for the use of a intervention

2. Review of Resident #17's record on revealed that the resident was admitted to the . The resident's record facility on documented that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after

Requirement to complete and document a debriefing session within 24 hours after use of and/or with

the staff involved in the emergency safety and/or appropriate and supervisory and administrative staff to review the circumstances resulting in the use of and 'strategies and/or to be used by the staff, the resident, or others that could further use prevent . If an injury is sustained by a resident during the use of and/or during the debriefing a plan to prevent further injury is to be developed and documented in

the medical record. · Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of

Revisions to the Restraint/Seclusion

Documentation requirements related

1 Expectations for full compliance to the policy Restraint/ documentation requirements.

PRINTED: 04/26/2019 FORM APPROVE OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

R WING

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED 04/08/2016

NAME OF PROVIDER OR SUPPLIER

SANDY PINES

10L014

STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE

TEQUESTA, FL 33469

SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY

(X5) COMPLETION

N 161 Continued From page 26

Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that , without doors at contained the two small that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes.

Review of Resident #16's record on revealed evidence of documentation that the resident was admitted to the facility on The resident's record revealed evidence of documentation that the facility sent the resident to receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection and the facility discharged the resident at that time.

Further review of the resident's record revealed no evidence that staff documented the) intervention in the resident's record, including that staff documented the date and time the team physician was consulted for the use of a

2. Review of Resident #17's record on revealed that the resident was admitted to the facility on . The resident's record documented that the facility sent the resident to a receiving facility on

Intervention

accompanied by Law Enforcement officers after

N 161 N 161 Continued

Competency was assessed via post-tests maintained in individual employee's HR file. Each employee taking the training was also required to sign an attestation of his/her understanding of the expectations for compliance with established policy and documentation Nurses were additionally requirements. required to complete a correctly completed set of documents to verify understanding of the documentation requirements. Any employee 2016 will failing to complete training by be required to complete the training before being allowed to return to work.

Facility ID: RC57000060P

If continuation sheet Page 27 of 48

561-427-1576 PRINTED: 04/26/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION

10L014

(X2) MULTIPLE CONSTRUCTION A BUEDING

(X3) DATE SURVEY c

NAME OF PROVIDER OR SUPPLIER

SANDY PINES (X4) ID

TAG

STREET ADDRESS, CITY, STATE, ZIP CODE

11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) APLETION DATE

. 2016

04/08/2016

N 161 Continued From page 26

Review on / / of the facility's own video recording revealed Residents #16 and #17 on

/ / at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes. Review of Resident #16's record on / / revealed evidence of documentation that the

resident was admitted to the facility on / / The resident's record revealed evidence of documentation that the facility sent the resident to receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection and the facility discharged the resident at that time. Further review of the resident's record revealed no evidence that staff documented the) intervention in the resident's record.

including that staff documented the date and time the team physician was consulted for the use of a intervention.

2. Review of Resident #17's record on / / revealed that the resident was admitted to the facility on 1 / . The resident's record documented that the facility sent the resident to a receiving facility on 1 /

accompanied by Law Enforcement officers after

N 161 N 161 Continued

Monitorine:

and ongoing The DON/designees and/or the 100%

of all documents related to the use of /seclusion on a daily basis to ensure compliance with documentation standards and policy expectations. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any noncompliance is addressed through retraining and/or disciplinary action as appropriate.

For a period of four months, the DON and conducting daily random audits via surveillance camera of each residential unit's area with each area viewed at least 2 time periods each shift. Any incident of is compared with nhserved 1 OF ./. documented to ensure that all episodes are correctly documented. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate. When compliance is maintained for four months, the monitored will be decreased to a sample of each shift weekly.

Responsible:

Director of Nursing

14:32:16

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/26/2016 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING ___ С 10L014 B. WING 04/08/2016

| NAME OF PROVIDER OR SUPPLIER SANDY PINES | | 1 | TREET ADDRESS, CITY, STATE, ZIP CODE 1301 SE TEQUESTA TERRACE TEQUESTA, FL. 33469 | | |
|--|---|---------------------|--|--------------------|--|
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | COMPLETION DATE | |
| | Continued From page 27 the resident disrupted the unit, instigated peers and was not responding to redirection. The resident's record revealed evidence of documentation that the facility re-admitted the resident on and discharged the resident on . Further review of the resident's record revealed no evidence that staff documented the () intervention in the resident's record interview of the resident's record revealed no evidence that staff documented the () intervention in the resident's record, including that staff documented the date and time the team physician was consulted for the use of a intervention. In an interview conducted on at 12:03 PM with the facility's Risk Manager, the Risk Manager reported that the facility was a locked facility, the units were also locked and she inquired whether this was a 483.364(d) MONITORING DURING AND AFTER A physician, or other licensed practitioner permitted by the state and the facility to evaluate the resident's well-being immediately after the resident's well-being immediately after the resident's well-being immediately after the resident's well-being immediately after the resident's well-being immediately after the resident's he facility falled to have a physician or a nurse evaluate the well-being of the residents immediately after the residents were removed from a for 2 of 17 sampled residents immediately after the residents were removed from a for 2 of 17 sampled residents reviewed for seclusions and (Resident #15). | | Corrective Actions: The Director Nursing (DON) and facility Risk Manager () reviewed and revised the facility policy related to the use and documentation of and " and | | |

14:32:36 016 EE 1<u>91</u>

| DEPART IMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICALD SERVICES STATEMENT OF DEFICIENCIES STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) DATE 8: COMPLE COMPLE 101.014 B. WING STRIET ADDRESS, CITY, STATE, 2/P CODE 11301 SE TEQUESTA TERRACE TEQUESTA, FL. 33469 (X4) D. SUMMARY STATEMENT OF DEFICIENCIES 10 PROVIDERS PLAN OF CORRECTION | 1-427-1576 | | | | | | PRINTED: | 04/26/20 |
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| SAND PINAS NAME OF PROVIDER OR SUPPLIER SANDY PINES NAME OF PROVIDER PIN OF CORRECTION SAME PROVIDER PIN OF CORRECTION SAME PROVIDER PIN OF CORRECTION SAME PROVIDER PIN OF CORRECTION CROSS-REPERBORD TO THE APPROPRIATE OF REQUIREMENT to fully document each use of and/or with the most recent reveword revealed that the policies and procedures documented a Registered Nurse (RN) to assess the resident of face to face following the () intervention. Observations conducted on approximately 9.25 AM, with the facility's Nurse Manager reported, during an interview, on a tapproximately 5.00 Pines place; the doors of the facility's own video recording revealed Residents #16 and #17 on at approximately 9.25 AM that the facility's own video recording revealed Residents #16 and #17 on at approximately 9.25 AM that the facility's own video recording revealed Residents #16 and #17 on at approximately 9.00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that contained the two small with the area was viold of any furniture, except for a plastic chair. There | DEPART | IMENT OF HEALTH | AND HUMAN SERVICES | | | | | APPROVE |
| NAME OF PROVIDER OR SUPPLIER SANDY PINES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) N 174 Continued From page 28 Review on of the facility's own policies and procedures titled, "and with the most recent review of that the policies and procedures titled," and with the most recent review of that the policies and procedures documented a Registered Nurse (RN) to assess the resident face to face following the (approximately 9.25 AM, with the facility's Nurse images revealed an area that contained two with doors in place; the doors opened out to a small common area that also contained a the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9.25 AM that the facility's own video recording revealed Residents #16 and #17 on at approximately 5.00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that contained the two small without doors at that time, leading into a common area that had a set of locked double doors. The area was volid of any furniture, except for a plastic chair. There | CENTER | RS FOR MEDICARE | & MEDICAID SERVICES | | | | OMB NO. | 0938-039 |
| IN 174 Continued From page 28 Review on of the facility's own policies and procedures titled, and with the most recent review of that the policies and procedures documented a Registered Nurse (RN) to assess the resident face to face following the () Intervention. Observations conducted on at approximately 9:25 AM, with the facility's Nurse in Manager revealed that the policies are the contained a from a hallway that led to common area that also contained a the area was separated from a hallway that led to common area by a set of double doors. The Nurse Manager reported, during an Interview, on at approximately 9:25 AM that the facility's own video recording revealed Residents #16 and #17 on at approximately 50.00 Miles of the facility is not the contained the facility of the facility is not the contained the facility of the facility is not the contained the face of the facility of the facility is not the contained the face of | STATEMENT AND PLAN O | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | COM | PLETED |
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| TRAIL SUMMARY STATEMENT OF DEFICIENCIES REACH DEFICIENCY MUST are PRECEDED BY FULL TAG | NAME OF F | PROVIDER OR SUPPLIER | · | | 1 | STREET ADDRESS, CITY, STATE, ZIP COD | | |
| TROUBSTA, FL. 33469 PROPRIETE TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG | | | | | 1 1 | 11301 SE TEQUESTA TERRACE | | |
| N 174 Continued From page 28 Review on of the facility's own policies and procedures titled, "and with the most recent review of revealed that the policies and procedures titled," and Registered Nurse (RN) to assess the resident face to face following the () Intervention. Observations conducted on approximately 92.55 AM, with the facility's Nurse Manager revealed an area that contained two with doors in place, the doors opened out to a small common area that also contained a the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to the to avoid but re-added them after a revision of their policies. Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 50-9M, locked away from other residents, in an area that they did not frequent at a part of their daily routines. The residents were observed in the area that contained the two small without doors at that time, leading into a common area that had a set of flocked double doors. The area was void of any furniture, except for a plastic chair. There | SANDY F | PINES | | | ١. | TEQUESTA, FL. 33469 | | |
| N 174 Continued From page 28 Review on of the facility's own policies and procedures titled, " and " with the most recent review of revealed that the policies and procedures documented a Registered Nurse (RN) to assess the resident face to face following the () intervention. Observations conducted on approximately 525 AM, with the facility's Nurse i Manager revealed an area that contained two with doors in place; the doors opened out to a small common area that also contained a the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 59:25 AM that the facility had taken off the doors to the contained them after a revision of their policies. Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 50-09 M, locked away from other residents, in an area that they did not frequent as part of their daily routines. The resident tis were observed in the area that contained the two small without doors at that time, leading into a common area hist had a set of locked double doors. The area was volid of any furniture, except for a plastic chair. There | PREFIX | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL | PREF | ΊX | (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API | OULD BE | (X8) COMPLETIO DATE |
| and procedures titled, " and " use of " and/or " use of " and/or " the that the policies and procedures documented a Registered Nurse (RN) to assess the resident face to face following the () Intervention. Observations conducted on a proximately 525 AM, with the facility's Nurse ideal approximately 525 AM, with the facility's Nurse ideal and a set of the area was separated or " the area was separated from a hallway that led to common area that also contained a " the area was separated of double doors. The Nurse Manager reported, during an interview, on at approximately 525 AM that the facility had taken off the doors the facility's own video recording revealed Residents #16 and #17 on at approximately 500 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The resident's were observed in the area that contained the two small without doors at that time, leading into a common area that had a set of locked double doors. The area was volid of any furniture, except for a plastic chair. There | N 174 | • | - | N | 174 | N 174 Continued | | ; |
| residents were observed kicking the double discussion must include the doors, the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes. Reviaw of Resident #16's record on revealed evidence of documentation that the resident, or others that could prevent the future use of / The resident's record revealed evidence of The resident of the facility on the resident was admitted to the facility on the resident of | | Review on and procedures title with the most recer that the policies an Registered Nurse (face to face following the face of t | of the facility's own policies did not revealed a procedures documented a RNN) to assess the resident gith () intervention at the contained the contained two intervention at the contained two intervention are at the contained two intervention are at the contained two intervention are at the doors in place; the doors all common area that also the area was separated led to common area by a set enurse Manager reported, on at approximately, on at approximately and the common area by a set in the contained with the common area that the contained with the containe | 1 . 1 | | Requirement to fully do use of and/or Requirement to docum medical record, the eme situation that required, use of and/or interventions used, and of the intervention Requirement to docume of all staff involved in and/or. Need to consult with treatment team physical and document that consults the date/time of the consequence of the consequence of the consequence of the consequence of the consequence of consequence of the removed from and to does | hent in the rigency safety flustified the the outcome in the notion in the names the outcome in the names the case of the names the case of the names in the name | · · · · · · · · · · · · · · · · · · · |

PRINTED: 04/26/2016 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION A. BUILDING C 10L014

04/08/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE SANDY PINES TEQUESTA, FL 33469 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (XS) MPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX N 174 Continued N 174 Continued From page 28 N 174 Review on of the facility's own policies Requirement to complete and and procedures titled, " and document a debriefing session within with the most recent review of revealed 24 hours after use of : and/or that the policies and procedures documented a with the staff involved in the Registered Nurse (RN) to assess the resident emergency safety and/or face to face following the () Intervention. and appropriate supervisory Observations conducted on and administrative staff to review the approximately 9:25 AM, with the facility's Nurse circumstances resulting in the use of Manager revealed an area that contained two and/or and , with doors in place; the doors strategies to be used by the staff, the opened out to a small common area that also resident, or others that could prevent ; the area was separated contained a further use of 1 , If an from a hallway that led to common areas by a set injury is sustained by a resident during of double doors. The Nurse Manager reported, the use of and/or during an Interview, on at approximately during the debriefing a plan to prevent 9:25 AM that the facility had taken off the doors to further injury is to be developed and to avoid , but the documented in the medical record. re-added them after a revision of their policies. Requirement to obtain and document Review on of the facility's own video medical treatment promptly for any recording revealed Residents #16 and #17 on injury sustained by a resident during at approximately 5:00 PM, locked away the use of /seclusion. from other residents, in an area that they did not , 2016 frequent as part of their daily routines. The The DON and and revised all medical records forms related to the residents were observed in the area that , without doors at documentation of the use of contained the two small to ensure that all required elements could be that time, leading into a common area that had a documented correctly and thoroughly. set of locked double doors. The area was void of any furniture, except for a plastic chair. There The DON, , and designees, along with: , 2016 was a staff member present in the area. The Corporate Divisional Clinical Directors, provided residents were observed kicking the double retraining to all nurses, direct care staff, doors; the doors did not open when kicked. They attending psychiatrists, and senior leadership on: were observed pacing back and forth in the area Definition of and appropriate and this lasted at least 5 minutes. and/or justification for use of Review of Resident #16's record on during for an emergency revealed evidence of documentation that the safety situation resident was admitted to the facility on Revisions/clarifications to The resident's record revealed evidence of Policy including: documentation that the facility sent the resident to

receiving facility on

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| | | & MEDICAID SERVICES | | | | C | OMB NO. | |
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| AND PLAN O | IF CORRECTION | IDENTIFICATION NUMBER: | A. BUILD | NG_ | | | 1 | LETED |
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| NAME OF F | PROVIDER OR SUPPLIER | | - (| | | , CITY, STATE, ZIP CODE | | |
| SANDY F | INES | | - 1 | | | STA TERRACE | | |
| | | | | 18 | QUESTA, FL | | | |
| (X4) ID : | | EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL | ID PREFI | | | DER'S PLAN OF CORRECTS ORRECTIVE ACTION SHOUL | | (X6) COMPLETI |
| TAG | | C IDENTIFYING INFORMATION) | TAG | ^ : | CROSS-RE | FERENCED TO THE APPRO | | DATE |
| | | | | | | DEFICIENCY) | | |
| - ' | ı | | | , | N 174 Contin | wed | | |
| N 174 | Continued From page | ge 28 | N 1 | 74 | | Who may authorize ti | ne use of | |
| | | of the facility's own policies | | | • | and/or | | |
| | and procedures title | | | | | Requirement to o | btain a | |
| | | review of / / revealed | | | | physician's order for a | ny use of | |
| | | Procedures documented a RN) to assess the resident | | | | and/or | | |
| | | g the () intervention. | | | • | Requirement to cond document a face | | |
| | Observations condu | | | | | assessment of the re | | |
| | approximately 9:25 | AM, with the facility's Nurse | | | | later than one hour | | |
| | | n area that contained two | | | | initiation of the | | |
| | | th doors in place; the doors | | | | Access of the con- | | |
| | | all common area that also | | | • | Requirement to fully | | |
| | | ; the area was separated led to common areas by a set | | | | each use of | . ano/or | |
| | | eo to common areas by a set e Nurse Manager reported, | | | _ | Requirement to docum | ent in the | |
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during an interview, on / / at approximately 9:25 AM that the facility had taken off the doors to to avoid the ා, but re-added them after a revision of their policies. of the facility's own video Review on / recording revealed Residents #16 and #17 on / / at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They

were observed pacing back and forth in the area

revealed evidence of documentation that the

resident was admitted to the facility on / /

documentation that the facility sent the resident to

receiving facility on / /

The resident's record revealed evidence of

and this lasted at least 5 minutes.

Review of Resident #16's record on

safety situation required/justifled the use of , the and/or interventions used, and the outcome of the intervention Requirement to document the names of all staff involved in the and/or Need to consult with the treatment team resident's physician for the and and to document that consultation including the date/time of the consult. Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the

PRINTED: 04/26/2016

14:33:46 561-427-1576 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION A. BUILDING C B. WING 101.014 04/08/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE SANDY PINES TEQUESTA, FL 33469 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (X6) COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 174 Continued N 174 N 174 Continued From page 28 of the facility's own policies Requirement to conduct and and procedures titled, " and document a face to face revealed with the most recent review of discussion with all staff and the that the policies and procedures documented a resident involved in an emergency Registered Nurse (RN) to assess the resident intervention. The discussion must face to face following the () intervention. include the circumstances Observations conducted on resulting in the use of approximately 9:25 AM, with the facility's Nurse and/or and strategies to Manager revealed an area that contained two be used by the staff, the resident, , with doors in place; the doors or others that could prevent the opened out to a small common area that also future use of ; the area was separated contained a Requirement to complete and from a hallway that led to common areas by a set document a debriefing session of double doors. The Nurse Manager reported, within 24 hours after use of during an interview, on at approximately : and/or with 9:25 AM that the facility had taken off the doors to the staff involved in the emergency safety and/or emergency safety to avoid seclusions, but the re-added them after a revision of their policies. and appropriate of the facility's own video supervisory and administrative Review on recording revealed Residents #16 and #17 on staff to review the circumstances resulting in the use of at approximately 5:00 PM, locked away and/or ___ and 'strategles from other residents, in an area that they did not to be used by the staff, the

frequent as part of their daily routines. The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The

doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes. Review of Resident #16's record on revealed evidence of documentation that the resident was admitted to the facility on The resident's record revealed evidence of documentation that the facility sent the resident to

receiving facility on

residents were observed kicking the double

Facility ID: RC57000080P

prevent

use of

the medical record.

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resident, or others that could

further use of

sustained by a resident during the

during the debriefing a plan to

prevent further injury is to be

developed and documented in

Requirement to obtain and

document medical treatment

promptly for any injury sustained

by a resident during the use of

/seclusion. If an injury is

and/or

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| 427-1576 DEPARTMENT OF HEALTH CENTERS FOR MEDICARE | | | PRINTED: 04/26/ FORM APPRO DMB NO. 0938- |
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| | 10L014 | 8. WING | C 04/08/201 |
| NAME OF PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE | |

SANDY PINES

11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION ID (X4) ID PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIE PREFIX DEFICIENCY)

N 174 Continued From page 28

Review on of the facility's own policies and procedures titled, " with the most recent review of revealed that the policies and procedures documented a

Registered Nurse (RN) to assess the resident face to face following the () intervention. Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors

opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to to avoid seclusions, but re-added them after a revision of their policies.

of the facility's own video Review on recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their dally routines. The residents were observed in the area that , without doors at contained the two small that time, leading into a common area that had a set of locked double doors. The area was vold of any furniture, except for a plastic chair. There

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receiving facility on

was a staff member present in the area. The

N 174 Continued N 174

Revisions to the forms

Documentation requirements related to restraint/seclusion

Expectations for full compliance to the 1 policy and documentation requirements.

Competency was assessed via post-tests maintained in Individual employee's HR file. Each employee taking the training was also required to sign an attestation of his/her understanding of the expectations for compliance with established policy and documentation Nurses were additionally requirements. required to complete a correctly completed set of documents to verify understanding of the documentation requirements. Any employee falling to complete training by , 2016 will be required to complete the training before being allowed to return to work.

Facility ID: RC57000060P

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/26/2016 FORM APPROVED OMB NO. 0938-0391

04/08/2016

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

10L014

(X2) MULTIPLE CONSTRUCTION A. BUILDING _

B. WING

(X3) DATE SURVEY COMPLETED С

NAME OF PROVIDER OR SUPPLIER

SANDY PINES

STREET ADDRESS, CITY, STATE, ZIP CODE

11301 SE TEQUESTA TERRACE

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (XB) COMPLETION DATE |
| N 174 | Continued From page 29 accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection and the facility discharged the resident at that time. Further review of the resident's record revealed no evidence that staff documented the () Intervention in the resident's record, including no evidence of documentation a physician or a nurse evaluated the well-being of the resident immediately after the resident was removed from a 2. Review of Resident #17's record on revealed that the resident was admitted to the facility on . The resident's record documented that the facility sent the resident to a | N 17 | DEFICIENCY) N 174 Continued Monitoring: | , 2016 and ongoing |
| | receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection. The resident's record revealed evidence of documentation that the facility re-admitted the resident on and discharged the resident on . Further review of the resident's record revealed no evidence that staff documented the () intervention in the resident's record revealed no evidence that staff documented the () intervention in the resident's record, including no evidence of documentation a physician or a nurse evaluated the well-being of the resident immediately after the resident was removed from a | | area with each area viewed at least 2 time periods each shift. Any incident of observed or is compared with documented or is compared with documented or is compared with all episodes are correctly occumented. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate. When compliance is maintained for four months, the monitored will be decreased to a sample of each shift weekly. Responsible: | |
| N 179 | In an interview conducted on at 12:03 PM with the facility's Risk Manager, the Risk Manager reported that the facility was a locked facility, the units were also locked and she inquired whether this was a 483.366 NOTIFICATION OF PARENT(S) OR | . N 1 | Director of Nursing | |
| 14 1/0 | TOURD HOTELONION OF TRICEIN (O) ON | | · - | - 1 |

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| DEPARTMENT OF HEALTH CENTERS FOR MEDICARE | | | | | | INTED: 04/26/2016 FORM APPROVED IB NO. 0938-0391 |
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MU A. BUILL | TIPLE CONSTRUCTION | | (| X3) DATE SURVEY COMPLETED |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X6) COMPLETION DATE |
| N 178 | Continued From page 30 LEGAL GUARDIAN | N 178 | Corrective Actions: | , 201 |
| | If the resident is a minor as defined in this subpart: 483.366(a) The facility must notify the parent(s) or legal guardian(s) of the resident who has been restrained or placed in as soon as possible after the initiation of each emergency safety intervention. This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility falled to notify the resident's legal guardians that the residents had a for 2 of 17 sampled residents reviewed for and (Resident #16 and #17). | | The Director Nursing (DDN) and facility Risk Manager () reviewed and revised the facility policy related to the use and documentation of and and and and and and and and and and | |
| | The findings included: Review on of the facility's own policies | | document a face to face assessment of the resident no later than one hour after the initiation of the and/or | · · |
| | and procedures titled," and "with the most recent review of revealed that the policies and procedures documented a Registered Nurse (RN) to "notify the resident's parent or quardian of the or a second or a seco | | Requirement to fully document each use of | |
| | soon as possible after the initiation of the or | | use of and/or _, the Interventions used, and the outcome of the intervention Requirement to document the names | |
| | Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two with doors in place; the doors opened out to a small common area that also | | of all staff involved in the and/or. Need to consult with the resident's treatment team physician for the and and to document that consultation including | - - |
| | contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately | | the date/time of the consult. | |

14:35:15

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 04/26/2016 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES
STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDERSUPPLIERICLIA
IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED C 04/08/2016

NAME OF PROVIDER OR SUPPLIER

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETIC DATE |
| N 170 | Continued From page 31 | N 178 | N 178 Continued | į |
| 14 170 | | N 178 | | |
| | 9:25 AM that the facility had taken off the doors to | | Requirement for an MO or nurse to evaluate the well-being of the resident | |
| | the to avoid seclusions, but | | immediately after the resident is | |
| | re-added them after a revision of their policies. | | removed from and/or | 1 |
| | Review on of the facility's own video | | and to document that | |
| | recording revealed Residents #16 and #17 on | | evaluation Need to notify the resident's legal | |
| | at approximately 5:00 PM, locked away | | guardian that the resident had a | |
| | from other residents, in an area that they did not | | and/or and | |
| | frequent as part of their daily routines. The | | document that notification | |
| | residents were observed in the area that | | - Regulrement to conduct and | |
| | contained the two small , without doors at | | document a face to face discussion | |
| | that time, leading into a common area that had a | | with all staff and the resident involved | |
| | set of locked double doors. The area was vold of | | in an emergency intervention. The | |
| | any furniture, except for a plastic chair. There | | discussion must include the | i |
| | was a staff member present in the area. The | | circumstances resulting in the use of | |
| | residents were observed kicking the double | | and/or and | |
| | doors; the doors did not open when kicked. They | | strategies to be used by the staff, the | 1 |
| | were observed pacing back and forth in the area | | resident, or others that could prevent | Ç. |
| | and this lasted at least 5 minutes. | | the future use of / | |
| | Review of Resident #16's record on | | Requirement to complete and | |
| | revealed evidence of documentation that the | | document a debriefing session within | |
| | resident was admitted to the facility on | | 24 hours after use of and/or | |
| | The resident's record revealed evidence of | | with the staff involved in the | |
| | documentation that the facility sent the resident to | | emergency safety and/or | |
| | a receiving facility on | | and appropriate supervisory and administrative staff to review the | |
| | accompanied by Law Enforcement officers after | | circumstances resulting in the use of | |
| | the resident disrupted the unit, instigated peers | | and/or and | |
| | and was not responding to redirection and the | | strategies to be used by the staff, the | |
| | facility discharged the resident at that time. | | resident, or others that could prevent | |
| | Further review of the resident's record revealed | | further use of / If an | |
| | no evidence that staff documented the | | injury is sustained by a resident during | į |
| | () intervention in the resident's record, | | the use ofand/or | - |
| | including no evidence of documentation that the | | during the debriefing a plan to prevent | 1 |
| | facility notified the resident's guardian of the | | further injury is to be developed and | |
| | * | | documented in the medical record. | |
| | i | | Requirement to obtain and document | İ |
| | B. D. J. C. Braidest #47te second on | | medical treatment promptly for any | |
| | 2. Review of Resident #17's record on | | injury sustained by a resident during | i |
| | revealed that the resident was admitted to the | | Alex com and all | 1 |

STATEMENT OF DEFICIENCIES

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NAME OF PROVIDER OR SUPPLIER

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING_

PRINTED: 04/26/20 FORM APPROVE OMB NO. 0938-039

(X3) DATE SURVEY COMPLETED 04/08/2016

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STREET ADDRESS, CITY, STATE, ZIP CODE

11301 SE TEQUESTA TERRACE

TEQUESTA, FL 33469

SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG TAG N 178 N 178 Continued N 178 Continued From page 31

9:25 AM that the facility had taken off the doors to

to avoid seclusions, but re-added them after a revision of their policies.

of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that , without doors at contained the two small that time, leading into a common area that had a set of locked double doors. The area was vold of any furniture, except for a plastic chair. There

was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes. Review of Resident #16's record on revealed evidence of documentation that the resident was admitted to the facility on The resident's record revealed evidence of documentation that the facility sent the resident to

receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection and the facility discharged the resident at that time. Further review of the resident's record revealed no evidence that staff documented the) intervention in the resident's record, including no evidence of documentation that the facility notified the resident's guardian of the

2. Review of Resident #17's record on revealed that the resident was admitted to the The DON and

and revised ail medical records forms related to the documentation of the use of to ensure that all required elements could be documented correctly and thoroughly.

, and designees, along with The DON, Corporate Divisional Clinical Directors, provided retraining to all nurses, direct care staff, attending psychiatrists, and senior leadership on: Definition of and appropriate justification for use of and/or during for an emergency

safety situation Revisions/clarifications to the Restraint/Seclusion Policy including: Who may authorize the use of

and/or obtain Requirement to physician's order for any use of and/or

Requirement to conduct and document a face to face assessment of the resident no later than one hour after the initiation of the and/or

Requirement to fully document each use of and/or

Requirement to document in the medical record, the emergency safety situation that required/justified the use of , the and/or interventions used, and the outcome of the Intervention Requirement to document the

names of all staff involved in the

and/or

28 / 56 PRINTED: 04/26/20 FORM APPROVE OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION

A. BUILDING

04/08/2016

(X5) MPLETION DATE

NAME OF PROVIDER OR SUPPLIER

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B. WING

STREET ADDRESS, CITY, STATE, ZIP CODE

11301 SE TEQUESTA TERRACE

TEQUESTA, FL 33469

SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) TAG

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N 178 Continued From page 31

9:25 AM that the facility had taken off the doors to , but to avoid re-added them after a revision of their policies.

of the facility's own video Review on recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away num other residents, in an area that they did not

frequent as part of their daily routines. The residents were observed in the area that , without doors at contained the two small that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes. Review of Resident #16's record on revealed evidence of documentation that the resident was admitted to the facility on The resident's record revealed evidence of

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documentation that the facility sent the resident to

including no evidence of documentation that the facility notified the resident's guardian of the

2. Review of Resident #17's record on revealed that the resident was admitted to the

N 178 N 178 Continued

- Need to consult with the treatment team resident's physician for the and and to document that consultation including date/time of the consult.
- Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and to document and/or that evaluation
- Need to notify the resident's legal guardian that the resident had a and/or and document that notification Requirement to conduct and
- document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must Include the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent the future use of

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(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED

(X1) PROVIDER/SUPPLIER/CLIA A. BUILDING __

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C 04/08/2016

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469

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STATEMENT OF DEFICIENCIES

NO PLAN OF CORRECTION

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION (X4) ID TAG

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)

N 178 Continued

N 178 Continued From page 31

9:25 AM that the facility had taken off the doors to to avoid seclusions, but re-added them after a revision of their policies.

of the facility's own video Review on recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their dally routines. The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was vold of any furniture, except for a plastic chair. There was a staff member present in the area. The

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2. Review of Resident #17's record on revealed that the resident was admitted to the N 178

Requirement to complete and document a debriefing session within 24 hours after use of and/or with the staff involved in the emergency safety and/or and annronriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and strategles to be used by the staff, the resident, or others that could prevent further use of . If an Injury is sustained by a resident during the use of and/or during the debriefing a plan to prevent further injury is to be developed and documented in

the medical record. Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of /seclusion

Revisions to the forms Documentation requirements related

Expectations for full compliance to the policy 1 and documentation requirements.

04/08/2016

(X5) COMPLET DATE

, 2016

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PREFIX

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVE CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING e, WING

NAME OF PROVIDER OR SUPPLIER

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TAG

STREET ADDRESS, CITY, STATE, ZIP CODE

11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469 PROVIDER'S PLAN OF CORRECTION

N 178 Continued From page 31

9:25 AM that the facility had taken off the doors to to avoid seclusions, but re-added them after a revision of their policies.

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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of the facility's own video Review on recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They

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the resident disrupted the unit, instigated peers and was not responding to redirection and the facility discharged the resident at that time. Further review of the resident's record revealed no evidence that staff documented the) intervention in the resident's record, including no evidence of documentation that the

2. Review of Resident #17's record on

facility notified the resident's guardian of the

N 178 Continued

N 178 Competency was assessed via post-tests maintained in individual employee's HR file. Each employee taking the training was also required to sign an attestation of his/her understanding of the expectations for compliance with established policy and documentation requirements. Nurses were additionally required to complete a correctly completed set of documents to verify understanding of the documentation requirements. Any employee , 2016 will falling to complete training by be required to complete the training before being allowed to return to work.

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY

The DON/designees and/or the 100% of all documents related to the use of and ongoing on a daily basis to ensure restraint/ compliance with documentation standards and policy expectations. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any noncompliance is addressed through retraining and/or disciplinary action as appropriate.

revealed that the resident was admitted to the FORM CMS-2587(02-89) Previous Versions Obsolete

Facility ID: RC57000060P

If continuation sheet Page 32 of 48

14:37:05 PRINTED: 04/26/2011 FORM APPROVE OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING ___

(X3) DATE SURVEY COMPLETED С

04/08/2016

10L014

B. WING

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE

| SANDY F | PINES | | 11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469 | |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| N 178 | Continued From page 32 facility on . The resident's record documented that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted the until, instigated peers and was not responding to redirection. The resident's record revealed evidence of documentation that the facility re-admitted the resident on and discharged the resident on . Further review of the resident's record revealed no evidence that staff documented the () Intervention in the resident's record, including no evidence that the facility notified the resident's guardian of the | N 17 | N 178 Continued For a period of four months, the DON and are conducting daily random audits via surveillance camera of each residential unit's surveillance camera of each residential unit's came area with each area viewed at least 2 time periods each shift. Any incident of observed or is compared with documented / to some content of all episodes are correctly documented. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility. PI Committee and quartarity to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriates. When compliance is maintained for four months, the monitored will be decreased to a sample of each shift weekly. | |
| N 188 | In an Interview conducted on at 12:03 PM with the facility's Risk Manager, the Risk Manager reported that the facility was a locked facility, the units were also locked and she inquired whether this was a 483.370(a) POST INTERVENTION DEBRIEFINGS | N 11 | Responsible: Director of Nursing | |
| | Within 24 hours after the use of the programmer in staff involved in an emergency safety intervention and the resident must have a face-to-face discussion. This discussion must include all staff involved in the intervention except when the presence of a staff person may jeopardize the wellbeing of the resident. Other staff and the resident's parent(s) or legal guardian(s) may participate in the discussion when it is deemed appropriate by the facility. The facility must conduct such discussion in a language that is understood by the resident and by the resident's parent(s) or legal guardian(s). The discussion must provide both the resident | | Corrective Actions: The Director Nursing (DON) and facility Risk Manager () reviewed and revised the facility policy related to the use and documentation of and " and " to ensure that are required elements are included and clearly stated for staff interpretation. Key elements of the policy include: | , 20 1 |

| 1-427-1576 | | | | |
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| DEPARTMENT OF HEALTH | AND HUMAN SERVICES | | | PRINTED: 04/26/2016 FORM APPROVED |
| CENTERS FOR MEDICARE | & MEDICAID SERVICES | | | OMB NO. 0938-0391 |
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUI A. BUILL | TIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | 1 | | С |
| | 10L014 | B. WING | | 04/08/2016 |
| NAME OF PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| SANDY PINES | | | 11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469 | |
| | TEMENT OF DEFICIENCIES | ID. | PROVIDER'S PLAN OF CORRECT | |

| SANDY PINES | | | ı | 11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469 | | |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X6) COMPLETION DATE | |
| N 188 | Continued From page 33 | N 1 | 188 | N 188 Continued | | |
| | and staff the opportunity to discuss the | | | - Clarification on the definition of | | |
| | circumstances resulting in the use of or | | | and | | |
| | and strategies to be used by the staff, | | | - Who may authorize the use of | | |
| | the resident, or others that could prevent the | | | and/or | | |
| | future use of or | | | Requirement to obtain a physician's | | |
| | | | | order for any use of and/or | | |
| | This STANDARD is not met as evidenced by: | | | - Requirement to conduct and | | |
| | Based on record review, observation and | | | document a face to face assessment of | ı | |
| | interview, the facility failed to conduct a face to | | | the resident no later than one hour | : | |
| | face discussion with staff involved in an | | | after the initiation of the | | |
| | emergency safety intervention and the resident to | | | and/or | | |
| | include the required discussion requirements for | | | - Requirement to fully document each use of and/or | | |
| | 3 of 17 sampled residents reviewed for | | | - Requirement to document in the | | |
| | and (Resident #14, 16 and | | | medical record, the emergency safety | | |
| | #17). | | | situation that required/justified the | | |
| | | | | use of and/or the | | |
| | · | | | interventions used, and the outcome | | |
| | The findings included: | | | of the intervention | | |
| | | | | - Requirement to document the names | | |
| | Review on of the facility's own policies | | | of all staff involved in the | | |
| | and procedures titled " and" | | | and/or | | |
| | with the most recent review of revealed | | | - Need to consult with the resident's | | |
| | that the policies and procedures documented the | | | treatment team physician for the | | |
| | resident and staff involved in a / | | | and and to | | |
| | to participate in a debriefing as soon as possible, | | | document that consultation including | | |
| | but no later than 24 hours after the initiation of the | | | the date/time of the consult. | | |
| | or . According to the policies | | | - Requirement for an MD or nurse to | | |
| | and procedures, "Staff involved in the procedure | | | evaluate the well-being of the resident | | |
| | may be excused from the debriefing if they are no | | | immediately after the resident is removed from and/or | | |
| | longer on the shift or if their participation is | | | removed from and/or and to document that | : | |
| | assessed by the nurse to be potentially | | | evaluation | | |
| | detrimental to the resident or staff. The resident | | | - Need to notify the resident's legal | | |
| | debriefing sheet will be discussed and | | | guardian that the resident had a | | |
| | completed." | | | and/or and | | |
| | Review of Resident #14's record on revealed that the resident had a | | | document that notification | | |
| | from 7:11 PM to 7:16 PM. Further review | | | | | |
| | of the resident's record revealed evidence of | | | ž | | |
| | of the resident's record revealed evidence of | | | | | |

| 1-427-157 | 6 | | | | 14:37:49 | | |
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| DEPART | MENT OF HEALTH | AND HUMAN SERVICES | | | F | PRINTED: 04/26/2 FORM APPROV | |
| CENTER | RS FOR MEDICARE | & MEDICAID SERVICES | | | | MB NO. 0938-0 | |
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | TIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
| | | 10L014 | B. WING | | | 04/08/2016 | |
| NAME OF E | PROVIDER OR SUPPLIER | | <u> </u> | STREET ADDRESS, C | ITY, STATE, ZIP CODE | 1 04/00/2016 | |
| SANDY F | PINES | | | 11381 SE TEQUEST TEQUESTA, FL 3 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFE TAG | (EACH COR | R'S PLAN OF CORRECTION SHOUL RECTIVE ACTION SHOUL RENCED TO THE APPROI DEFICIENCY) | D BE COMPLET | 10 |
| | | | | N 188 Continue | đ | | _ |
| N 188 | the resident, or oth future use of This STANDARD is Based on record in interview, the facilit face discussion with emergency safety include the requires | unity to discuss the | N 1 | 86 Requir docum with all in an discussion circum stratege resident the fut - Requir docum 24 hou and additional and additional and additional and additional and additional additional additional and additional | ement to conduction a face to face of a staff and the resident emergency intervention must includ intervention must includ intervention and/or gles to be used by the int, or others that couldnt, or others that couldnt. | iscussion involved on. The e the e use of and staff, the involved on within and/or et of the e use of and/or et of the e use of the use of the use of the e use of the e use of the e use of the e use o | |
| | resident and staff if to participate in a d but no later than 24 or and procedures, "S may be excused fr longer on the shift assessed by the ni | of the facility's own policies ad " and " revealed " and " revealed procedures documented the wolved in a behrefing as soon as possible, hours after the initiation of the According to the policies taff involved in the procedure on the debriefing if they are no or if their participation is rise to be potentially seldent or staff. The resident | | strateg resider further injury i the us during further docum Requir medica injury | ties to be used by the sent, or others that could use of / is sustained by a residen | staff, the prevent if an nt during prevent ped and cord. ocument for any | |

completed."
Review of Resident #14's record on revealed that the resident had a on from 7:11 PM to 7:16 PM. Further review

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| DEPARTMENT OF HEALTH CENTERS FOR MEDICARE | | | FORM APPRO OMB NO. 0938-0 | |
|---|---|--|-------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | (X3) DATE SURVEY COMPLETED | |
| | 10L014 | 8. WING | C 04/08/2016 | |

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE SANDY PINES TEQUESTA, FL 33469 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLET DATE m PREFIX TAG DEFICIENCY N 188 Continued N 188 Continued From page 33 N 188 The DON and RM reviewed and revised all May 4, 2016 and staff the opportunity to discuss the circumstances resulting in the use of medical records forms related to the and strategles to be used by the staff, documentation of the use of /seclusion | the resident, or others that could prevent the to ensure that all required elements could be or fulture use of documented correctly and thoroughly. , 2016 , and designees, along with The DON. This STANDARD is not met as evidenced by: Corporate Divisional Clinical Directors, provided Based on record review, observation and retraining to all nurses, direct care staff, attending psychiatrists, and senior leadership on: interview, the facility failed to conduct a face to Definition of and appropriate face discussion with staff involved in an justification for use of and/or emergency safety intervention and the resident to during for an emergency Include the regulred discussion requirements for safety situation 3 of 17 sampled residents reviewed for Revisions/clarifications seclusions and (Resident #14, 16 and Restraint/Seclusion Policy Including: #17). Who may authorize the use of and/or Requirement to obtain a The findings included: physician's order for any use of and/or 1. Review on of the facility's own policies · Requirement to conduct and and procedures titled " document a face to face with the most recent review of revealed assessment of the resident no later than one hour after the

that the policies and procedures documented the resident and staff involved in a to participate in a debriefing as soon as possible, but no later than 24 hours after the initiation of the . According to the policles Or and procedures, "Staff involved in the procedure may be excused from the debriefing if they are no longer on the shift or if their participation is assessed by the nurse to be potentially detrimental to the resident or staff. The resident debriefing sheet will be discussed and completed."

from 7:11 PM to 7:16 PM. Further review

Review of Resident #14's record on

revealed that the resident had a

each use of

Requirement to document in the medical record, the emergency safety elfication that required/justified the use of and/or , the interventions used, and the outcome of the intervention

Requirement to fully document

initiation of the

Requirement to document the names of all staff involved in the and/or

and/or :

and/or

| 1-427-1576 | | | | | 14:38:32 | | 1 |
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| | | AND HUMAN SERVICES | | | | | 04/26/20 |
| | | & MEDICAID SERVICES | | | | | APPROVE |
| | | | | | | | 0938-039 |
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDIN | | CONSTRUCTION | COM | SURVEY |
| | | 10L014 | B. WING _ | | | 04/6 |) 18/2016 |
| NAME OF F | PROVIDER OR SUPPLIER | | | ST | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| SANDY P | INES | | - 1 | | 301 SE TEQUESTA TERRACE | | |
| | | | | 10 | QUESTA, FL 33469 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | BE IATE | (X5) COMPLETIO DATE |
| 11.400 | | | | | N 188 Continued | | |
| N 188 | Continued From pa | | N 18 | 8 | Need to consult with | the | |
| | and staff the oppor | | ' | | | team | |
| | circumstances resu | | i | | physician for the | and | |
| | and strat | egies to be used by the staff, ers that could prevent the | | | and to document | that | |
| | future use of | or | | | consultation including | the | |
| | initite use of | Oi 1. | | | date/time of the consult. | | |
| | : | | , | | Requirement for an MD or | | |
| | This STANDARD | s not met as evidenced by: | | | to evaluate the well-being o | | |
| | | eview, observation and | , | | resident immediately after resident is removed from | | |
| | | y falled to conduct a face to | | | and/or and to docu | | |
| | | h staff involved in an | | | that evaluation | | |
| | emergency safety i | ntervention and the resident to | | | Need to notify the resident's | legal | |
| | | discussion requirements for | | | guardian that the resident | | |
| | | sidents reviewed for | | | and/or | and | |
| | seclusions and | (Resident #14, 16 and | | | document that notification | | |
| | #17). | | | | Requirement to conduct | | |
| | | | | | document a face to | face | |
| | | | | | discussion with all staff an | | |
| | The findings includ | ed: | | | resident involved in an emer intervention. The discussion | | |
| | 1. Review on | of the facility's own policies | | | include the circumst | | |
| | and procedures title | | | | resulting in the use of | | |
| | with the most recer | | | | and/or and strate | zies to | |
| | | d procedures documented the | | | be used by the staff, the re- | ildent, | |
| | resident and staff in | | | | or others that could preve | nt the | |
| | | ebriefing as soon as possible, | | | future use of /seclu | sion. | |
| | | hours after the initiation of the | | | | | |
| | ar | . According to the policies | | | | | |
| | and procedures, "S | taff involved in the procedure | | | | , | |
| | may be excused from | om the debriefing if they are no | | | | | |
| | | or if their participation is | | | | | |
| | assessed by the nu | rse to be potentially | | | | | |
| | detrimental to the r | esident or staff. The resident | | | | | |

debriefing sheet will be discussed and completed." Review of Resident #14's record on revealed that the resident had a ____on from 7:11 PM to 7:16 PM. Further review NAME OF PROVIDER OR SUPPLIER

14:38:52

PRINTED: 04/26/2010 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA

(X2) MULTIPLE CONSTRUCTION A. BUILDING _

OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED C 04/08/2016

10L014

A WING

STREET ADDRESS, CITY, STATE, ZIP CODE

11301 SE TEQUESTA TERRACE

SANDY PINES TEQUESTA, FL 33469 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) (X5) COMPLETION DATE PREFIX N 188 Continued N 188 Continued From page 34 N 188 documentation of a resident debriefing that Requirement to complete and at 8:00 PM and included only occurred on document a debriefing session within 24 hours after use of two staff members, a Mental Health Technician and a Registered Nurse. The "Administrative · and/or with Debriefing" included an additional Registered the staff involved in the Nurse and an addition Mental Health Technician. emergency safety and/or appropriate The records documented that the additional and Registered Nurse and Mental Health Technician supervisory and administrative had also participated in the resident's staff to review the circumstances intervention. In an interview conducted on resulting In the use of and/or and 'strategies at 1:54 PM with the Risk Manager and the Nurse to be used by the staff, the Manager, the participants acknowledged the resident, or others that could findings. prevent further use of restraint/seclusion. If an injury is sustained by a resident during the 2. Observations conducted on and/or use of approximately 9:25 AM, with the facility's Nurse during the debriefing a plan to Manager revealed an area that contained two prevent further injury is to be , with doors in place; the doors developed and documented in opened out to a small common area that also the medical record. contained a the area was separated Requirement to obtain and from a hallway that led to common areas by a set document medical treatment of double doors. The Nurse Manager reported, promptly for any injury sustained during an interview, on at approximately by a resident during the use of 9:25 AM that the facility had taken off the doors to /seclusion the to avoid seclusions, but Revisions to the re-added them after a revision of their policies. forms of the facility's own video Documentation requirements related recording revealed Residents #16 and #17 on . 1 m at approximately 5:00 PM, locked away - Expectations for full compliance to the from other residents, in an area that they did not policy and frequent as part of their dally routines. The documentation regulrements. residents were observed in the area that , without doors at contained the two small that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The

residents were observed kicking the double

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

14:39:14

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED

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04/08/2016

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING __

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STREET ADDRESS, CITY, STATE, ZIP CODE

| | - 1 | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
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| ANDY PINES | | 11301 SE TEQUESTA TERRACE | | |
| | | TEQUESTA, FL 33469 | | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) | PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETIO DATE | |
| N 188 Continued From page 35 doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this tasted at least 5 minutes. Review of Resident #16's record on revealed evidence of documentation that the resident was admitted to the facility on The resident's record revealed evidence of documentation that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection and the facility discharged the resident at that time. Further review of the resident at that time. Further review of the resident at that time. Further review of the resident at staff documented the () Intervention in the resident's record, including that the resident and staff debriefing occurred after the 3. Review of Resident #17's record on revealed that the resident was admitted to the facility on . The resident's record resident documented that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident stream of the revealed evidence of documentation that the facility re-admitted the resident on . Further review of the resident's record revealed evidence of documented the () intervention in the resident's record revealed on evidence that staff documented the () intervention in the resident and staff debriefing occurred after the Eurther review of the resident and staff debriefing occurred after the Eurther review of the resident on . | N 18 | N 188 Continued | , 20 and ongo | |

revealed evidence of documentation that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

SANDY PINES

561-427-1576 DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING _

PRINTED: FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED C 04/08/2016

10L014 NAME OF PROVIDER OR SUPPLIER

B. WING

STREET ADDRESS, CITY, STATE, ZIP CODE

11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469

| | | | TEQUESTA, FL 33409 | | |
|--------------------------|--|---------------------|--|-------------------|--|
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | COMPLETIO DATE | |
| N 188 | Continued From page 36 the resident had a on Review of the documentation, in the resident's record revealed two staff members were involved in the provider the staff members were documented, "off the unit" and excused from the resident debriefing on at 11:05 AM. The resident's record revealed that both staff members were available and participated to the "Administrative debriefing," on at 12:15 PM, approximately one hour later. In an interview conducted on at 12:03 PM with the facility's Risk Manager, the Risk Manager reported that the facility was a locked facility, the units were also locked and she inquired whether this was a in an interview conducted on at 1:54 PM with the facility's Risk Manager, the participants acknowledged the findings. 483.370(b) POST INTERVENTION DEBRIEFINGS Wikhin 24 hours after the use of all staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, must conduct a debriefing session that includes, at a minimum, a review and discussion of the precipitating factors that led up to the intervention; | N 188 | conducting daily random audits via surveillance camera of each residential unit's area with each area viewed at least 2 time periods each shift. Any incident of observed or is compared with documented / to ensure that all episodes are correctly documented. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through returning and/or disciplinary action as appropriate. When compliance is maintained for four months, the monitored will be decreased to a sample of each shift weekly. Responsible: | | |
| | This ELEMENT is not met as evidenced by: Based on record review, observation and | 3 | | | |

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 04/26/201 FORM APPROVEI

OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED

04/08/2016

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING ___

(X2) MULTIPLE CONSTRUCTION

С

NAME OF PROVIDER OR SUPPLIER

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

STREET ADDRESS, CITY, STATE, ZIP CODE

| SANDY F | PINES | | 11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469 | | | |
|--------------------------|--|---------------------|--|---------------------------|--|--|
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETIO DATE | | |
| | | | N 189 Continued | | | |
| N 189 | Continued From page 37 | N 189 | Literaturi | | | |
| | interview, the facility falled to conduct a debriefing | | - Requirement to conduct and | | | |
| | session within 24 hours after the use of a | | document a face to face assessment of | | | |
| | and or with the staff involved in | | the resident no later than one hour | | | |
| | the emergency safety and | | after the initiation of the | | | |
| | intervention and appropriate supervisory and | | - Requirement to fully document each | | | |
| | administrative staff for 3 of 17 sampled residents | | use of restraint and/or | | | |
| | reviewed for seclusions and (Resident | | - Requirement to document in the | | | |
| | #14, #16 and #17). | | medical record, the emergency safety | | | |
| | , | | situation that required/justified the | ! | | |
| | The findings included: | | use of and/or the | | | |
| | THE Initings included. | | Interventions used, and the outcome | | | |
| | Review on of the facility's policies and | | of the intervention | | | |
| | procedures titled " and "with | | - Requirement to document the names | } | | |
| | the most recent review of revealed that | | of all staff involved in the | | | |
| | the policies and procedures documented, "All | | and/or | | | |
| | staff involved in placing a resident in or | | - Need to consult with the resident's | 1 | | |
| | , participants as well as witnesses and | | treatment team physician for the | | | |
| | appropriate supervisory staff, are included in a | | and and to | | | |
| | staff debriefing discussion of what took place as | | document that consultation including | | | |
| | soon as possible after the incident occurs. The | | the date/time of the consult. | 1 | | |
| | Staff Debriefing Sheet will be completed and | | - Regulrement for an MD or nurse to | | | |
| | discussed no later than 24 hours after the event." | | evaluate the well-being of the resident | | | |
| | discussed the later than 24 hours and the event. | | immediately after the resident is | | | |
| | Review, on of Resident #14's record | | removed from and/or | | | |
| | revealed evidence of documentation that the | | and to document that | 1 | | |
| | resident had physical on from | | evaluation | 1 | | |
| | 6:18 PM to 6:27 PM; however, there was no | | - Need to notify the resident's legal | 1 | | |
| | evidence of documentation that the facility | | guardian that the resident had a | 1 | | |
| | attempted to conduct a staff/administrative | | and/or and | | | |
| | debriefing after the In an Interview | | document that notification | | | |
| | conducted on at 1:54 PM with the | | - Requirement to conduct and document a face to face discussion | | | |
| | facility's Risk Manager and the facility's Nurse | | with all staff and the resident involved | | | |
| | Manager, the participants acknowledged the | | in an emergency intervention. The | | | |
| | findings. | | discussion must include the | | | |
| | and and | | circumstances resulting in the use of | 1 | | |
| | | | and/or and | 1 | | |
| | 2. Observations conducted on at | | strategies to be used by the staff, the | 1 | | |
| | approximately 9:25 AM, with the facility's Nurse | | resident, or others that could prevent | : | | |
| | Manager revealed an area that contained two | | the future use of / | | | |

| HEALTH AND | HUMAN | SERVICES |
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DEPARTMENT OF CENTERS FOR MEDICARE & MEDICAID SERVICES

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING_

(X3) DATE SURVEY

10L014

B. WING

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

SANDY PINES

TAG

11301 SE TEQUESTA TERRACE

TEQUESTA, FL 33469

SUMMARY STATEMENT OF DEFICIENCIES (X4) (D Ю (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT COMPLETION DATE

04/08/2016

N 189 Continued From page 37

interview, the facility failed to conduct a debriefing session within 24 hours after the use of a with the staff involved in and or

the emergency safety and intervention and appropriate supervisory and administrative staff for 3 of 17 sampled residents reviewed for seclusions and (Resident #14, #16 and #17).

The findings included:

of the facility's policies and 1. Review on the most recent review of " with revealed that the policies and procedures documented, "All staff involved in placing a resident in

, participants as well as witnesses and appropriate supervisory staff, are included in a staff debriefing discussion of what took place as soon as possible after the incident occurs. The Staff Debriefing Sheet will be completed and discussed no later than 24 hours after the event."

Review, on of Resident #14's record revealed evidence of documentation that the resident had physical ดก from 6:18 PM to 6:27 PM; however, there was no evidence of documentation that the facility attempted to conduct a staff/administrative debriefing after the . In an interview at 1:54 PM with the conducted on facility's Risk Manager and the facility's Nurse Manager, the participants acknowledged the findings.

2. Observations conducted on approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two

N 189 Continued

Requirement to complete and document a debriefing session within 24 hours after use of and/or with the staff involved in the and/or emergency safety and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent -1 . If an further use of injury is sustained by a resident during the use of and/or during the debriefing a plan to prevent further injury is to be developed and documented in the medical record. Requirement to obtain and document

DEFICIENCY

medical treatment promptly for any injury sustained by a resident during

and revised all The DON and medical records forms related to the · 7 documentation of the use of to ensure that all required elements could be documented correctly and thoroughly.

the use of

, and designees, along with The DON, Corporate Divisional Clinical Directors, provided retraining to all nurses, direct care staff, attending psychiatrists, and senior leadership on: Definition of and appropriate and/or justification for use of during for an emergency safety situation the

Revisions/clarifications to Policy including:

| | | AND HUMAN SERVICES | | | | | FORM | 04/26/20 APPROVI |
|--------------------------|--|--|----------------------|-----|-------------------------------|---|---|---------------------|
| STATEMENT AND PLAN C | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | LE CONSTRUCTA | | (X3) DAT | E SURVEY PLETED |
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| NAME OF F | PROVIDER OR SUPPLIER | | | | | S, CITY, STATE, ZIP CODE | 1 | <u> </u> |
| SANDY F | PINES | | | | 1301 SE TEQUI TEQUESTA, FI | ESTA TERRACE L 33469 | | |
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| | session within 24 h and or the emergency safe intervention and administrative staff reviewed for sactus #14, #16 and #17). The findings includ 1. Review on procedures titled " the most recent rev the policies and pro staff involved in pla appropriate superv staff debriefing discoon as possible a Staff Debriefing Staff or | y falled to conduct a debriefing ours after the use of a with the staff involved in sty and propriate supervisory and for 3 of 17 sampled residents ions and (Resident ed: if of the facility's policies and and "with leve of revealed that spectures documented," All | N 1 | 189 | N 189 Contin | Who may authorize the and/or Requirement to obta physician's order for any and/or Requirement to conduct document a face to assessment of the residiater than one hour affinitiation of the Requirement to fully doesn't use of Requirement to document medical record, the safety situation required/justified the candor and/or | and a use of and face eent no current and/or tin the ergency that use of b, the d the n ent the | |
| | revealed evidence resident had physic 6:18 PM to 6:27 PM | of Resident #14's record of documentation that the tal on from it, however, there was no entation that the facility | | | • | Need to consult with resident's treatment physician for the and to docume consultation including data/time of the consult. | team and | |

attempted to conduct a staff/administrative

debriefing after the In an interview conducted on at 1:54 PM with the

. In an interview

approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two

and

date/time of the consult.

resident is removed from

and/or

document that notification

and/or

Facility ID: RC57000060P

that evaluation · Need to notify the resident's legal guardian that the resident had a

Requirement for an MD or nurse

to evaluate the well-being of the resident immediately after the

and to document

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039

04/08/2016

| | FORM APPRO OMB NO. 0938- |
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| a ment mann | COMPLETED |

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

10L014

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING

NAME OF PROVIDER OR SUPPLIER

B. WING STREET ADDRESS, CITY, STATE, ZIP CODE

11301 SE TEQUESTA TERRACE SANDY PINES TEQUESTA, FL 33469 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID PREFIX TAG (X5) MPLETION DATE 153 (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) REF DEFICIENCY) N 189 Continued N 189 Continued From page 37 N 189 Requirement to conduct and Interview, the facility failed to conduct a debriefing document a face to face session within 24 hours after the use of a discussion with all staff and the and or with the staff involved in resident involved in an emergency and the emergency safety intervention. The discussion must intervention and appropriate supervisory and include the circumstances administrative staff for 3 of 17 sampled residents resulting in the use of reviewed for and (Resident and strategies to #14, #16 and #17). be used by the staff, the resident. or others that could prevent the The findings included: future use of Requirement to complete and document a debriefing session 1. Review on of the facility's policies and the most recent review of within 24 hours after use of revealed that and/or with the staff involved in the the policies and procedures documented, "All emergency safety and/or staff involved in placing a resident in , participants as well as witnesses and and appropriate supervisory and administrative appropriate supervisory staff, are included in a staff to review the circumstances staff debriefing discussion of what took place as resulting in the use of soon as possible after the incident occurs. The and/or and 'strategles Staff Debriefing Sheet will be completed and to be used by the staff, the discussed no later than 24 hours after the event." resident, or others that could further prevent use of Review, on of Resident #14's record /seclusion. If an injury is revealed evidence of documentation that the sustained by a resident during the resident had physical On from use of : and/or 6:18 PM to 6:27 PM; however, there was no during the debriefing a plan to evidence of documentation that the facility prevent further injury is to be attempted to conduct a staff/administrative developed and documented in

Manager, the participants acknowledged the findings. 2. Observations conducted on approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two

facility's Risk Manager and the facility's Nurse

the medical record. Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of /seclusion

debriefing after the

conducted on

, in an interview

at 1:54 PM with the

B. WING ___

14:41:25 PRINTED: 04/28/2016 FORM APPROVED OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

10L014

(X2) MULTIPLE CONSTRUCTION

A. BUILDING __

(X3) DATE SURVEY COMPLETED С 04/08/2016

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | ID. | PROVIDER'S PLAN OF CORRECTION | (MS) |
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| PREFIX TAG | (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | COMPLETIO DATE |
| | | | N 189 Continued | 1 |
| N 189 | Continued From page 38 "with doors in place; the doors opened out to a small common area that also contained a the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to the load of the facility of the doors to the load of the facility of the doors to the load of the facility of the facility of the doors to the load of the facility of the resident disrupted the unit, instigated peers and was not responding to report of the facility o | N 189 | | |
| | Further review of the resident's record revealed no evidence that staff documented the () intervention in the resident's record, including no evidence that the staff/administrative debriefing occurred after the | | | |

Facility ID: RC57000060P

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16 D 91

| | | AND HUMAN SERVICES | | F | NTED: 04/26/2016 ORM APPROVED |
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| CENTER | RS FOR MEDICARE | & MEDICAID SERVICES | | OME | 3 NO. 0938-0391 |
| TATEMENT NO PLAN O | O DI ANI OF DODDEGTION . DESTREMANDO . | | (X2) MULTIPI A. BUILDING | | (3) DATE SURVEY COMPLETED |
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| NAME OF F | PROVIDER OR SUPPLIER | | 5 | TREET ADDRESS, CITY, STATE, ZIP CODE | |
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| N 189 | Continued From pa | ge 39 | N 189 | N 189 Continued | |
| | facility on documented that the recident disrupt and was not responding the recident flow of the recident flow of the recident flow of the recident on on Further record revealed no documented the (so resident's record, it staff/administrative in an interview con with the facility's Riceported that the fa | usident was admitted to the . The resident's record to a facility on the resident to a facility on the facility on the facility on the facility on the facility of the facility of the facility of the facility of redirection. The vesied evidence of the facility re-admitted the and discharged the resident review of the resident's evidence that staff eclusion) intervention in the including no evidence that the debriefing occurred after the | | For a period of four months, the DON and conducting daily random audits surveillance camera of each residential unarea with each area viewed at leime periods each shift. Any laciden observed or is compared documented / to ensure all episodes are correctly documented in the conduction of the conducti | via Julit's ast 2 st of with that that nted. orted collity traing ough as as d for |
| N 196 | this was a | Red and she inquired whether J. AL TREATMENT FOR | N 196 | Corrective Actions: | |
| | from qualified med | ately obtain medical treatment ical personnel for a resident of an emergency safety | | The DON reviewed and reaffirmed the " and "" as accu-addressing the RNs' responsibilitie | rately s to |

Injuries after

This STANDARD is not met as evidenced by: Based on record review and interview, the facility falled to obtain medical treatment promptly for Injuries after for 3 of 17 sampled residents (Resident #7, #14 and #15).

assess/reassess any resident complaint of injury, determine the extent of the injury, and provide or secure appropriate medical care promptly

14:42:09

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

(X2) MULTIPLE CONSTRUCTION

PRINTED: 04/26/201 FORM APPROVEI OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTOR (X2) MULTIPLE CONSTRUCTOR (X3) MULTIPLE CONSTRUCTOR (X3) MULTIPLE CONSTRUCTOR (X4) MULTIPLE CO

C 04/08/2016

NAME OF PROVIDER OR SUPPLIER

10L014 B. WING_

STREET ADDRESS, CITY, STATE, ZIP CODE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

11301 SE TEQUESTA TER

| SANDY | PINES | - | 11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469 | | |
|--------------------------|---|---------------|---|--|--|
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE DTO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| N 196 | Continued From page 40 | N 16 | 96 | į | |
| | The findings include: 1. Review of Resident #7's record on revealed evidence of documentation that the resident had a physical on Further review of the residents record revealed evidence of documentation that a nurse assessed | | The DON provided training to all RNs on assessment/reassessment of injuries including timeliness of assessment, determining extent of injuries, providing or securing medical cor- promptly, and documenting all assessments and actions taken. Competency was assessed via post-test. Any RN urable to complete the training by 8 is required to complete training by 8 is required to complete the securing training the securing training by 8 is required to complete the securing training the securing training by 8 is required to complete the securing training training training the securing training the securing training the securing training trai | , 201€ | |
| | the resident on at 6:30 PM, noted "red marks on the resident's right arm, skin intact, reddened area to left eye and back pain from a former injury that the incident had aggravated;" | | training before their next shift. Monitoring: | | |
| | the "pain was" documented to be a "2" on scale of 1 to 10" however, there was no evidence of documentation of the source of the injury, any treatment in the packet, or nursing notes. There was no evidence of documentation that the nurse determined the extent of all injuries sustained during this and provided or secured the appropriate medical care promptly. The resident was no longer in the facility on | | The DON/designee monitors 100% of documentation related to the use of documentation related to the use of concluding mursing documentation to assess for adequacy of nursing documentation to assess for adequacy of nursing obtaining assessment/reassessment of any complaints of injury and the prompt provision of medical care. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through | , 2016 and ongoing | |
| | Review of Resident #14's record on revealed evidence of documentation that the | | retraining and/or disciplinary action as appropriate. Responsible: | of the state of th | |
| | resident had a physical on from 4:18 PM to 4:22 PM. The record documented that | | | | |
| | the one-hour assessment by a Registered Nurse (RN) was conducted at 7:00 PM and the delay was because of an "ongoing crisis on the unit." According to the RN's assessment documentation, there were no injuries noted at | | Director of Nursing | • | |
| | that time; however, during the resident debriefing, on at 1:24 PM, the RN documented, "The back of by (sic) ear was "A "late entry pursing note" for documented that the | | | | |
| | resident had superficial scratches on the arms. Resident #14 reported in an interview on | | | ! | |
| 1 | at 3:26 PM that staff scratched the resident; that | | i | 1 | |

FORM CMS-2567(02-99) Previous Versions Obsolete

the resident sustained scratches from the

Event ID: TIER11

Facility ID: RC57000080P

If continuation sheet Page 41 of 48

DEPARTMENT OF HEALTH AND HUMAN SERVICES

14:42:31 PRINTED: 04/26/2016
FORM APPROVED

| CENTER | RS FOR MEDICARE | & MEDICAID SERVICES | | | OMB NO | . 0938-039 |
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| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDI | FIPLE CONSTRUCTION NG | | TE SURVEY MPLETED |
| | | 10L014 | B. WING | | 04 | C /08/2016 |
| NAME OF F | PROVIDER OR SUPPLIER PINES | | | STREET ADDRESS, CITY, STATE, 28 11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFID TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO DEFICIENCY | ION SHOULD BE HE APPROPRIATE | (X5) COMPLETIO DATE |
| | stated that staff puroweer, a review / / reveled no related to the treat of documentation to extent of all injuries and provided or se care promptly. 3. Review on / / revealed that the number of discharback, teg and arm the highest pain or resident's record, to no / / administrative deb casess whether the injuries at that time documentation in a fall injuries sustaprovided or secure promptly. In an interview cor with the facility's Review 1. Nurse Manager, the 483.372(c) MEDIC INJURIES Staff involved in all that results in an little results in an | cent's ear turned purple and to internal on the scratches; of the resident's record on evidence of documentation ment. There was no evidence hat the RN determined the sustained during this cured the appropriate medical of Resident #15's record asident reported on / / , at get from the facility, pain in the scale). According to the resident had a physical, but the resident had a physical, but the resident had a sustained any . There was no evidence of it the RN determined the extent intend during this and d the appropriate medical care induced or / at 154 PM. Sk Manager and the facility's e participants acknowledged sident #7, #14 and #15. AL TREATMENT FOR | N 1: | | revised the facility | 200 |
| | meet with supervision circumstances that a plan to prevent f | ory staff and evaluate the t caused the injury and develop uture injuries. | | to ensure that are require included and clearly st interpretation. Key element | red elements are tated for staff | ! |

| 1-42/-15/6 | • | | | | n | DIATED. | 04/26/201 |
|--|---|---|-------------|-----------------------------------|---|--|---------------------------------|
| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | · | FORM A | 04/26/20 APPROVE 0938-039 |
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
| 10L014 | | | B. WING | | | C 04/08/2016 | |
| NAME OF F | PROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| SANDY F | INES · | | | | 301 SE TEQUESTA TERRACE EQUESTA, FL 33469 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | PREF TAG | IX (EACH CORRECTIVE ACTION SHOULD | | 18E ' | (X5) COMPLETION DATE |
| N 202 | Continued From pa | ne 42 | N: | יפחס ^י | N 202 Continued | | |
| | This ELEMENT is Based on record ir failed to have staff resulted in injuries evaluate the circum injuries and develo injuries for 3 of 17 suffered injuries du #14, and #15). The findings includ 1. Review of Resid revealed evidence resident had a phys | not met as evidenced by: volved in that meet with supervisory staff to stances that resulted in the p a plan to prevent further sampled residents who ring (Resident #7, e: ent #7's record on of documentation that the sical on | | | Clarification on the defining and | and/or and/or and isment of one hour ent each | |
| | evidence of docum the resident on marks on the reside reddened area to le former injury that it the "pain was" doct 1 to 10" however, it documentation of it treatment in the notes. The residen on The re | ne resident's record revealed entation that a nurse assessed at 6:30 PM, noted "red entation that a right arm, skin intact, off eye and back pain from a ne incident had aggravated." umented to be a "2 on scale of the rewas no evidence of assource of the injury, any packet, or nursing twas no longer in the facility sident's record failed to noe of documentation that the | | | medicar record, the environmental situation that required/just use of and/or interventions used, and the of the intervention of the intervention requirement to document to fail staff involved in the and/or. Need to consult with the treatment team physician and document that consultation the date/time of the consult. Requirement for an MD or an MD or | ified the | |

injuries.

staff involved in the

resident's injuries met with supervisory staff to evaluate the circumstances that resulted in the injuries and develop a plan to prevent further

resident had a physical on from 4:18 PM to 4:22 PM. The record documented that

2. Review of Resident #14's record on revealed evidence of documentation that the

that resulted in the

evaluate the well-being of the resident immediately after the resident is removed from and/or and to document that

Need to notify the resident's legal guardian that the resident had a and/or and

document that notification

evaluation

14-43-12 PRINTED: 04/26/2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION A. BUILDING B. WING 10L014 04/08/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 11301 SE TEQUESTA TERRACE SANDY PINES TEQUESTA, FL 33469 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) MPLETION DATE (X4) ID PREFIX ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COM TAG TAG DEFICIENCY) N 202 Continued N 202 Continued From page 42 This ELEMENT is not met as evidenced by: Regulrement conduct and to Based on record review and interview, the facility document a face to face discussion with all staff and the resident involved falled to have staff involved in that in an emergency intervention. The resulted in injuries meet with supervisory staff to must include the evaluate the circumstances that resulted in the discussion circumstances resulting in the use of injuries and develop a plan to prevent further and/or injuries for 3 of 17 sampled residents who strategies to be used by the staff, the suffered injuries during (Resident #7. resident, or others that could prevent #14, and #15). the future use of 1 Requirement to complete and The findings include: document a debriefing session within 24 hours after use of and/or 1. Review of Resident #7's record on with the staff involved in the revealed evidence of documentation that the emergency safety and/or resident had a physical and appropriate supervisory Further review of the resident's record revealed and administrative staff to review the evidence of documentation that a nurse assessed circumstances resulting in the use of and/or

the resident on at 6:30 PM, noted "red marks on the resident's right arm, skin intact, reddened area to left eye and back pain from a former injury that the incident had aggravated; the "pain was" documented to be a "2 on scale of 1 to 10" however, there was no evidence of documentation of the source of the injury, any treatment in the packet, or nursing notes. The resident was no longer in the facility . The resident's record falled to on revealed any evidence of documentation that the that resulted in the staff involved in the resident's injuries met with supervisory staff to evaluate the circumstances that resulted in the injuries and develop a plan to prevent further Injuries.

2. Review of Resident #14's record on revealed evidence of documentation that the from resident had a physical on 4:18 PM to 4:22 PM. The record documented that medical records forms related to the documentation of the use of ____/seclusion to ensure that all required elements could be documented correctly and thoroughly.

the use of/.....

further use of

the use of

The DON and

Facility ID: RC57000080P

strategies to be used by the staff, the

resident, or others that could prevent

injury is sustained by a resident during

during the debriefing a plan to prevent

further injury is to be developed and

Requirement to obtain and document

medical treatment promptly for any

injury sustained by a resident during

documented in the medical record.

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, 2016

and revised all

14:43:35 561-427-1576 PRINTED: 04/26/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING_ 101.014 B. WING 04/0B/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 11301 SE TEQUESTA TERRACE SANDY PINES TEQUESTA, FL 33469 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT (X4) ID PREFIX (X5) MPLETION DATE PREFIX ENCED TO THE APPROPRIATE
DEFICIENCY) REGULATORY OR LSC IDENTIFYING INFORMATION) TAG N 202 Continued N 202 Continued From page 42 N 202 The DON, 8,2016 , and designees, along with : This ELEMENT is not met as evidenced by: Corporate Divisional Clinical Directors, provided retraining to all nurses, direct care staff, Based on record review and interview, the facility failed to have staff involved in that attending psychiatrists, and senior leadership on: Definition of and appropriate resulted in injuries meet with supervisory staff to Justification for use of and/or evaluate the circumstances that resulted in the during for an emergency injuries and develop a plan to prevent further safety situation injuries for 3 of 17 sampled residents who Revisions/clarifications to (Resident #7. suffered injuries during Policy including: #14, and #15). Who may authorize the use of and/or The findings include: Requirement to physician's order for any use of 1. Review of Resident #7's record on and/or revealed evidence of documentation that the Requirement to conduct and resident had a physical On document a face to face Further review of the resident's record revealed assessment of the resident no

evidence of documentation that a nurse assessed at 6:30 PM, noted "red the resident on marks on the resident's right arm, skin intact, reddened area to left eye and back pain from a former injury that the incident had aggravated; the "pain was" documented to be a "2 on scale of 1 to 10" however, there was no evidence of documentation of the source of the injury, any packet, or nursing treatment in the notes. The resident was no longer in the facility

. The resident's record failed to

revealed any evidence of documentation that the

resident's injuries met with supervisory staff to

evaluate the circumstances that resulted in the

injuries and develop a plan to prevent further

injuries. 2. Review of Resident #14's record on revealed evidence of documentation that the resident had a physical on from 4:18 PM to 4:22 PM. The record documented that

date/time of the consult. Facility ID: RC57000060P

If continuation sheet Page 43 of 46

and and to document that

later than one hour after the

Requirement to fully document

Requirement to document in the

medical record, the emergency

required/justified the use of

interventions used, and the outcome of the intervention

Requirement to document the

names of all staff involved in the

Need to consult with the

treatment team

including the

and/or

and/or

physician for the

resident's

consultation

situation

initiation of the

each use of

safety

..... and/or

and/or

that

, the

staff involved in the

on

that resulted in the

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

14:43:57

PRINTED: 04/26/2016
FORM APPROVEC
OMB NO. 0938-0391

(X3) DATE SURVEY

A. BUILDING ___

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

| | | | | | | | , | ٠ |
|--|---|-----------------------------------|---------|------|---------------------|---|------------|------------|
| | | 10L014 | B. WING | | | | 04/0 | 08/2016 |
| NAME OF PROVIDER OR SUPPLIER | | | | STR | EET ADDRESS, | CITY, STATE, ZIP CODE | | |
| SANDY PINES | | | 1 | 1130 | D1 SE TEQUE | STA TERRACE | | |
| SANDY | PINES | | | TEC | QUESTA, FL | 33469 | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ID. | | PROVI | DER'S PLAN OF CORRECTIO | N . | (X5) |
| PRÉFIX | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL | PREFU | κ. | (EACH CO | PRRECTIVE ACTION SHOULD | BE ' | COMPLETION |
| TAG | REGULATORY OR I. | SC IDENTIFYING INFORMATION) | TAG | | CROSS-REI | FERENCED TO THE APPROP DEFICIENCY) | RIATE | DATE |
| | | | | | | | | |
| | , | | | | 202 Continu | | | |
| N 202 | Continued From pa | ge 42 | N 2 | 02 | • | Requirement for an MD | | |
| | This FI EMENT IS | not met as evidenced by: | | | | to evaluate the well-bell | | |
| | | eview and Interview, the facility | | - 1 | | resident immediately a | | |
| | falled to have staff | | | | | resident is removed from | | |
| | | neet with supervisory staff to | | | | and/or and to d | ocument | |
| | | stances that resulted in the | | | | that evaluation | | i |
| | | a plan to prevent further | | | • | Need to notify the reside | | |
| | | sampled residents who | | | | guardian that the reside | | |
| | | ring restraints (Resident #7, | | | | and/or | and | |
| | #14, and #15). | ring restraints (resident in); | | į. | | document that notification | | |
| | . #15, unu #10). | | | | • | Requirement to cond | | |
| | The findings include | a• | | | | document a face | | |
| | the monda monda | z, | | | | discussion with all staff resident involved in an er | | |
| 4. Daview of Davidont #7's s | | ant #7's record on | | | | Intervention. The discuss | | |
| | Review of Resident #7's record on revealed evidence of documentation that the | | | | | | mstances | |
| | resident had a phys | | | | | resulting in the use of | marances | |
| | | e resident's record revealed | | | | and/or and stra | terior to | ì |
| | | entation that a nurse assessed | | | | be used by the staff, the | | |
| | the resident on | at 6:30 PM, noted "red | | | | or others that could pre | | |
| | | ent's right arm, skin intact. | | | | future use of restraint/se | | |
| | | oft eve and back pain from a | | | | Regulrement to comp | | |
| | | | | | | document a debriefing | | |
| | former injury that the incident had aggravated;" the "pain was" documented to be a "2 on scale of | | | | | within 24 hours after | | |
| | | nere was no evidence of | | | | and/or | with | |
| | | ne source of the injury, any | | | | the staff involved | in the | 1 |
| | treatment in the | packet, or nursing | | | | emergency safety | and/or | |
| | | was no longer in the facility | ! | | | and ap | propriate | |
| | | ident's record failed to | | | | supervisory and admit | nistrative | : |
| | | nce of documentation that the | | | | staff to review the circu | mstances | 1 |
| | staff involved in the | | | | | resulting in the use of | | : |
| | | net with supervisory staff to | | | | and/or and | | 1 |
| | | | | | | to be used by the s | | |
| | evaluate the circumstances that resulted in the injuries and develop a plan to prevent further | | | | | resident, or others th | | |
| | Injuries and develop | o a plantio proventi turnici | | | | | ise of | |
| | ii ijui iea. | | | | | | Injury is | |
| | 2 Review of Reside | ent #14's record on | | | | sustained by a resident of | uring the | |
| | | of documentation that the | | | | use of and/or during the debriefing a | nian c- | |
| ľ | resident had a phys | | | | | prevent further injury | | |
| | | | | | | developed and docum | | |
| 4:18 PM to 4:22 PM. The record documented that | | | | | developed and docum | enteo In | | |

the medical record.

PRINTED: 04/26/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A. BUILDING_ 101 014 04/08/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE SANDY PINES TEQUESTA, FL 33469 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX (XS) PLETION PREFIX TAG N 202 Continued N 202 Continued From page 42 N 202 · Regulrement to obtain and document medical treatment This ELEMENT is not met as evidenced by: promptly for any injury sustained Based on record review and Interview, the facility by a resident during the use of falled to have staff involved in that resulted in injuries meet with supervisory staff to Revisions to the Restraint/ evaluate the circumstances that resulted in the forms injuries and develop a plan to prevent further Documentation requirements related injuries for 3 of 17 sampled residents who /seclusion to suffered injuries during (Resident #7. Expectations for full compliance to the #14, and #15). policy documentation requirements. The findings include: Competency was assessed via post-tests maintained in individual employee's HR file. Each employee taking the training was also required

1. Review of Resident #7's record on revealed evidence of documentation that the resident had a physical on Further review of the resident's record revealed evidence of documentation that a nurse assessed the resident on at 6:30 PM, noted "red marks on the resident's right arm, skin intact, reddened area to left eye and back pain from a former injury that the incident had aggravated; the "pain was" documented to be a "2 on scale of 1 to 10" however, there was no evidence of documentation of the source of the injury, any treatment in the packet, or nursing notes. The resident was no longer in the facility on . The resident's record failed to revealed any evidence of documentation that the staff involved in the that resulted in the resident's injuries met with supervisory staff to evaluate the circumstances that resulted in the injuries and develop a plan to prevent further injuries.

2. Review of Resident #14's record on revealed evidence of documentation that the resident had a physical on 4:18 PM to 4:22 PM. The record documented that the one-hour assessment by a Registered Nurse

requirements.

The DON/designees and/or the . 100% of all documents related to the use of and ongoing /seclusion on a dally basis to ensure compliance with documentation standards and policy expectations. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any noncompliance...)s addressed through retraining and/or disciplinary action as appropriate.

to sign an attestation of his/her understanding

established policy and documentation

required to complete a correctly completed set

of documents to verify understanding of the

documentation requirements. Any employee

be required to complete the training before

falling to complete training by

being allowed to return to work.

Nurses were additionally

of the expectations for compliance with

Facility ID: RC57000060P

If continuation sheet Page 43 of 48

, 2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

14:44:43

PRINTED: 04/26/2010 FORM APPROVE OMB NO. 0938-039 (X3) DATE SURVEY

C

04/08/2016

CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING _

B. WING

10L014

DEPARTMENT OF HEALTH AND HUMAN SERVICES

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE

SANDY PINES TEQUESTA, FL 33469 SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID PREFIX (X5) COMPLET DATE ID REFIX N 202 N 202 Continued N 202 Continued From page 43 (RN) was conducted at 7:00 PM and the delay was because of an "ongoing crisis on the unit." According to the RN's assessment For a period of four months, the DON and documentation, there were no injuries noted at : conducting dally random audits via that time; however, during the resident debriefing, surveillance camera of each residential unit's at 1:24 PM, the RN documented, "The seclusion area with each area viewed at least 2 back of by (sic) ear was ." A "late entry time periods each shift. Any incident of nursing note" for documented that the observed is compared with or resident had superficial scratches on the arms. to ensure that documented Resident #14 reported in an interview on all episodes are correctly documented. Aggregated results of the monitoring is reported at 3:26 PM that staff scratched the resident; that monthly by the Director of Nursing to the facility the resident sustained scratches from the PI Committee and quarterly to the Governing , the resident's ear turned purple and stated that staff put ointment on the scratches. Body. Any non-compliance is addressed through retraining and/or disciplinary action as The resident's record failed to reveal an appropriate. When compliance is maintained for evidence of documentation that the staff involved four months, the monitored will be decreased to that resulted in these injuries met a sample of each shift weekly. with supervisory staff to evaluate the circumstances that resulted in these injuries and Responsible: develop a plan to prevent further injuries. Director of Nursing 3, 3, Review on of Resident #15's record revealed that the resident reported on the time of discharge from the facility, pain in the back, leg and arms, rated at 4-5 (with 10 being the highest pain on the scale). According to the resident's record, the resident had a physical , but the resident and administrative debriefings were not conducted to assess whether the resident had sustained any injuries at that time. The resident's record failed to reveal any evidence of documentation that the staff involved in these that resulted in the resident's injuries met with supervisory staff to evaluate the circumstances that resulted in the injuries and develop a plan to prevent further

Injuries. In an interview conducted on 1:54 PM with the facility's Risk Manager and the

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14:45:05 PRINTED: 04/26/201 FORM APPROVE

04/08/2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING __

OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED С

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

| SANDY PINES | | | 11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469 | | |
|--------------------------|--|---------------------|---|-------------------|--|
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | COMPLETIO DATE | |
| N 202 | Continued From page 44 | N 20 | 2 | | |
| | acknowledged the findings for Resident #7, #14 and #15. | | Corrective Actions: | , | |
| N 222 | 483.376(f) EDUCATION AND TRAINING | N 22 | 2 | , 20 | |
| | Staff must demonstrate their competencies as specified in paragraph (a) of this section on a semiannual basis and their competencies as specified in paragraph (b) of this section on an annual basis. This ELEMENT is not met as evidenced by: | | The CEO provided written expectations to the Human Resources Director (HRD) regarding compilance with semi-annual training expectations and her responsibilities to ensure that all staff complete refresher training within six months of previous training. The CEO further instructed that any direct care staff not completing training, now or in the future in a | | |
| | Based on record review and interview, the facility failed to ensure that 9 of 10 sampled direct care employees demonstrated competency in the use | | timely fashion would be suspended until the training has been completed. | | |
| | of on a semiannual basis This affected 6 of 17 sampled Residents, Resident #1, #7, #14, #15, #16 and #17, who these employees restrained (Employee A, B, C, D, E, F, G, I, and J). | | The HRD/designees completed a 100% audit of all HR files of direct care staff to assess compliance with completion of Behavior Management training which includes the use of and least restrictive interventions. As a result of that audit, a list of | , 20 | |
| | The findings included: | | employees requiring refresher training was developed. | : | |
| | Review on of the facility's own policies and procedures titled, "Aggressive Behavior Management", with the most recent revision of revealed that "All direct care staff will receive refreshers class every 6 months and will | | The scheduled and Residential Manager and Nurse Manager ensured that any direct care employee not current in their semi-annual training related to the use of least restrictive | 8, 201 | |
| | receive education regarding the use of least restrictive measures in effectively managing aggressive residents." Review on of Employee A's personnel file revealed that the employee a Mental Health | | interventions and use of seclusion were scheduled for extra classes which were held the week of Any employee not current with training by have been suspended until they complete the course. Training documentation is maintained in each employee's | | |
| | Technician (MHT) Supervisor received their most recent training related to seclusions and | | training file. | | |
| | on | | The HRO submitted to the CEO verification of the completion of training for all staff requiring training related to the least restrictive interventions and the use of and/or | 8, 201 | |

14-45-27

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/26/2016 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MILLTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 10L014 B. WING 04/08/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11301 SE TEQUESTA TERRACE SANDY DINES TEQUESTA, FL 33469 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) VPLETION DATE (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREEIX DEFICIENCY) N 222 Continued From page 45 N 222 their most recent training related to seclusions . Review on Monitoring . 2016 : on The HRD submits a monthly report to the CEO Resident #15's record revealed that this and ongoing and Senior Leadership of any staff member not employee performed a physical in compliance with training requirements that resident, documented as a personal prone have been suspended pending completion of from 4:18 PM to 4:20 from on training and staff members requiring completion of training in the upcoming month. An aggregated summary is provided to the Governing Body on a quarterly basis. 3) Review on of Employee C's personnel file revealed that the employee, a MHT Supervisor, received their most recent training Responsible: related to seclusions and េលា of Resident #17's record Review on Human Resources Director revealed that the employee performed a physical on the resident, documented as a personal vertical ດດ PM to 7:55 PM, less than one minute. of Employee D's personnel 4) Review on file revealed that the employee, a MHT, received their most recent training related to seclusions . Review on and on Resident #17's record revealed that the employee on the resident, performed a physical documented as a personal vertical , from 10:22 AM to 10:23 AM. Review on of Resident #7's record revealed that the employee performed a physical resident, documented as a personal horizontal , from 5:33 PM to 5:48 PM. OΠ of Employee E's personnel 5) Review on file revealed that the employee, a MHT, received their most recent training related to seclusions and ດກ

of Employee F's personnel

file revealed that the employee, a MHT, received

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

14:45:46 ...-.

1-427-1576
DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED OMB NO. 0938-039

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING

(X3) DATE SURVEY COMPLETED C 04/08/2016

PRINTED: 04/26/2011

10L014

B. WING
 STREET ADDRESS, CITY, STATE, ZIP CODE

11301 SE TEQUESTA TERRACE

SANDY PINES TEQUESTA, FL 33469 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID PREFIX (X5) MPLETIO DATE PREFIX TAG N 222 Continued From page 46 N 222 on 7) Review on of Employee G's personnel file revealed that the employee, a MHT Supervisor, received their most recent training related to seclusions and on of Resident #17's record Review on revealed that the employee performed a physical , documented as a personal vertical on the resident on from 3:45 to 3:48 PM. Review on of Resident #1's record revealed that the employee performed a physical on the resident, documented as a personal vertical on #16, from 12:50 PM to 12:51 PM and a personal horizontal from 12:58 PM to 12:59 PM, Review on of Resident #16's record revealed that the employee performed a physical the resident, documented as a personal prone on , from 3:55 PM to 4:07 PM. 8) Review on of Employee I's personnel file revealed that the employee, a MHT, received their most recent training related to seclusions and OΠ of Employee J's personnel 9) Review on file revealed that the employee, a MHT, received their most recent training related to seclusions and on . Review on Resident #14's record revealed that the employee performed a physical , documented as a personal horizontal on the resident on , from 11:46 AM to 11:47 AM; performed a physical documented as a personal on the resident on from 10:30 AM to 10:35 AM.

In an interview conducted on

/16 at 2:51 PM

14:46:04 2016 VED 0391

| DEPARTMENT OF HEALTH CENTERS FOR MEDICARE | | | RINTED: 04/26/20 FORM APPROVE MB NO. 0938-03 |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | (X3) DATE SURVEY COMPLETED |
| | | | C |
| | 10L014 | B. WING | 04/08/2016 |

STREET ADDRESS, CITY, STATE, ZIP CODE

11301 SE TEQUESTA TERRACE

| SANDY PINES | | | TEQUESTA, FL. 33469 | | |
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| N 222 | Continued From page 47 | N 2 | 22 | | |
| | with the facility's Human Resource Manager, the Human Resource Manager acknowledged the findings. | | | | - |
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ELIZABETH DUDEK SECRETARY

FED-EX OVERNIGHT 8086 3829 3602 SIGNATURE REQUIRED

, 2016

Administrator Sandy Pines 11301 S.E. Tequesta Terrace Tequesta, FL 33469

RE: CCR# 2016003021

Dear Administrator:

This letter reports the findings of a complaint survey of your facility commenced on and concluded on 2016 by a representative of this office. It was determined the Residential Treatment Facility for Children and Adolescents was not in compliance.

The following Conditions of Participation were Not Met:

| Fed - N - 0178 - 483,366 - Notification Of Parent(s) Or | Or Or Or Or Or Or Or t Team Physenent Team Pl fter Legal Guard | nysician | | | | |
|--|---|----------|--|--|--|--|
| Fed - N - 0161 - 483.364(d) - Monitoring During And After Fed - N - 0174 - 483.366 - Notification Of Parent(s) Or Legal Guardian Fed - N - 0188 - 483.370(a) - Post Intervention Debriefings Fed - N - 0189 - 483.372(a) - Medical Treatment For Injuries Fed - N - 0196 - 483.372(a) - Medical Treatment For Injuries | | | | | | |
| Fed - N - 0222 - 483.376(f) - Education And Training | guiico | | | | | |

Attached is the provider's copy of the Statement of Deficiencies and Plan of Correction, Form CMS 2567, which references all of the deficiencies.

Delray Beach Field Office 5150 Linton Boulevard, Suite 500 Delray Beach, FL 33484 Phone: (561) 381-5840; Fax: (561) 496-5924 AHCA.MyFlorida.com



Facebook.com/ACHAFlorida Youtube.com/AHCAFlorida Twitter.com/AHCA_FL SlideShare.net/AHCAFlorida You must provide the Agency with an acceptable Plan of Correction (PoC) for all deficiencies cited within ten calendar days from receipt of the Statement of Deficiencies and Plan of Correction, Form CMS 2567. Please complete a Plan of Correction (PoC) for the deficiencies, including the date corrective action was accomplished or is anticipated to be accomplished. Please sign and date page 1 on the bottom and return to this Field Office within ten calendar days of receipt of this faxed report. Failure to submit a reply within this time frame may jeopardize your certification status. All deficiencies must be corrected no later than 2016.

In order for a PoC to be acceptable, it must include the following elements: Core Elements of PoC:

- . How the corrective action will be accomplished for individuals found to have
- · been affected by the deficient practice;
- How the facility will identify other individuals who have the potential to be affected by the same deficient practice, and how the facility will act to protect individuals in similar situations;
- What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- How the facility will monitor its corrective actions/performance to ensure that
 the deficient practice is being corrected and will not recur, i.e. what program
 will be put into place to monitor the continued effectiveness of the systemic
 change to ensure that solutions are permanent; and
- When corrective action must be accomplished.

Be advised that the Agency is recommending termination of your Medicaid participation to be effective , 2016 which is 90 days from the date of the survey. The termination process provides an opportunity for you to make corrections and achieve compliance. A revisit will be conducted within 45 days of the survey if a PoC is received and accepted. The revisit will determine if your facility is in compliance with the Conditions of Participation.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the representative. If you have questions, please contact this office at (561) 381-5840.

Sincerely

Arlene Mayo-D. is Field Office Manager

AMD

Enclosure: CMS Form 2567

EESW